Hospital and Facility Guidelines

A procedure manual for Blue Shield network hospitals and facilities (including ambulatory surgery centers, behavioral health outpatient facilities, birthing centers, dialysis centers, residential treatment centers, and skilled nursing facilities)

February 2025

blue california

blueshieldca.com

Table of Contents

Section 1: Introduction

Section 2: Hospital and Facility Responsibilities

Section 3: Medical Care Solutions

Section 3: Medical Care Solutions *(cont'd.)*

Section 4: Billing and Payment

Section 4: Billing and Payment *(cont'd.)*

Section 4: Billing and Payment *(cont'd.)*

Section 5: Blue Shield Benefit Plans and Programs

Section 5: Blue Shield Benefit Plans and Programs *(cont'd.)*

Section 6: Capitated Hospital Requirements

Appendices

Appendix for Section 1

A. Glossary

Appendix for Section 2

There is no appendix for Section 2.

Appendix for Section 3

There is no appendix for Section 3.

Appendix for Section 4

A. Reimbursement for Outpatient Services

B. Blue Shield Medicare Advantage Required Billing Elements

C. Where to Send Claims

D. List of Incidental Procedures

E. List of Office-Based Ambulatory Procedures

F. UB-04 General Instructions

G. Reimbursement for Implants

Appendix for Section 5

A. The BlueCard® Program

Appendix for Section 6

A. Blue Shield Combined Eligibility / Capitation Report

B. Blue Shield Eligibility Adds and Terminations Report

C. Claims, Compliance Program, IT System Security, and Oversight Monitoring

This page intentionally left blank.

Section 1: Introduction

This page intentionally left blank.

Table of Contents

This page intentionally left blank.

Purpose of the Hospital and Facility Guidelines

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

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

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

Manual Orders and Updates

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

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

This manual is updated at least annually, in January.

Enrollment and Eligibility

For routine eligibility verification, the provider may:

- Log onto Provider Connection at www.blueshieldca.com/provider for current and historical eligibility and benefit information that is updated daily.
- Use the Customer Service toll-free number listed on the member's ID card.

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

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

Enrollment and Eligibility *(cont'd.)*

Premium Payment Policy

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

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

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

Blue Shield Enrollment Responsibilities to Members on the Exchange

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

Enrollment and Eligibility *(cont'd.)*

Retroactive Cancellation/Ineligible Member

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

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

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

Member Rights and Responsibilities – Blue Shield HMO and PPO Commercial Members

Blue Shield has established Member Rights and Responsibilities that all Blue Shield members receive in their *Evidence of Coverage (EOC)* or *Certificate of Insurance (COI).* The information below is taken from the Members EOC/COI.

Statement of Member Rights

Blue Shield health plan members have the right to:

Receive considerate and courteous care, with respect for your right to personal privacy and dignity.

1. Receive information about all health services available to you, including a clear explanation of how to obtain health services.
2. Receive information about your rights and responsibilities.
3. Receive information about your Blue Shield plan, the services we offer you, the Physicians and other Health Care Providers available to care for you.
4. Receive information about how your Blue Shield plan manages access to your personal information, when and how we use your data, including how we may share language needs with your provider(s).

Member Rights and Responsibilities – Blue Shield HMO and PPO Commercial Members *(cont'd.)*

Statement of Member Rights *(cont'd.)*

5. Select a PCP and expect their team to provide or arrange for all the care that you need (HMO members only).
6. Have reasonable access to appropriate medical and mental health services.
7. Participate actively with your physician or PCP in decisions regarding your medical and mental health care. To the extent the law permits, you also have the right to refuse treatment.
8. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or Benefit coverage.
9. An explanation of your medical or mental health condition, and any proposed, appropriate, or Medically Necessary treatment alternatives, so you can make an informed decision before you receive treatment. This includes available success/outcomes information, regardless of cost of Benefit Coverage.
10. Receive Preventive Health Services.
11. Know and understand your medical or mental health condition, treatment plan, expected outcome, and the effects these have on your daily living.
12. Have confidential health records, except when the law requires or permits disclosure. With adequate notice, you have the right to review your medical record with your Physician or PCP.
13. Communicate with, and receive information, from Customer Services in a language you can understand.
14. Update how you would like us to contact you as well as your race, ethnicity, language, sexual orientation, gender identity and preferred pronouns information on the member portal.
15. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
16. Be fully informed about the complaint and grievance process and understand how to use it without the fear of interruption in your health care.
17. Voice complaints or appeals about your Blue Shield plan or the care provided to you.
18. Make recommendations on Blue Shield's member rights and responsibilities policies.

Member Rights and Responsibilities – Blue Shield HMO and PPO Commercial Members *(cont'd.)*

Statement of Member Responsibilities

Blue Shield health plan members have the responsibility to:

1. Carefully read all Blue Shield health plan materials immediately after you are enrolled so you understand how to:
    a. Use your benefits;
    b. Minimize your out-of- pocket costs; and
    c. Follow the provisions of your health plan as explained in the *Evidence of Coverage* or *Health Service Agreement*.
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when you need it.
3. Provide, to the extent possible, information needed to provide appropriate care.
4. Understand your health problems and take an active role in developing treatment goals with your Physician or PCP, whenever possible.
5. Follow the treatment plans and instructions you and your Physician or PCP agree to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6. Ask questions about your medical or mental health condition and make certain that you understand the explanations and instructions you are given.
7. Make and keep medical and mental health appointments and inform your Health Care Provider ahead of time when you must cancel.
8. Communicate openly with your Physician or PCP so you can develop a strong partnership based on trust and cooperation.
9. Offer suggestions to improve the Blue Shield plan.
10. Help Blue Shield maintain accurate and current medical records by providing timely information regarding changes in your address, family status, and other plan coverage.
11. Notify Blue Shield as soon as possible if you are billed inappropriately or if they have any complaints or grievances.
12. Treat all Blue Shield personnel respectfully and courteously.
13. Pay your Premiums, Copayments, Coinsurance, and charges for non-covered Services in full and on time.
14. Follow the provisions of the Blue Shield Medical Management Programs.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans

All Blue Shield Medicare Advantage plan members receive in their *Evidence of Coverage (EOC)* a Statement of Member Rights and Responsibilities. The information below is taken from the Blue Shield Advantage plan EOC.

We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service.

You can update how you'd like us to contact you, as well as your race, ethnicity, language, and sexual orientation, gender identity, and pronouns information by visiting the member portal. Go to www.blueshieldca.com/login and click "My Profile" to update your personal details. This information helps us understand and support your specific needs and preferences. We understand the importance of keeping your personal information private and confidential, and we take our obligations to do so seriously. We have policies and procedures in place to manage access to determine when and how we use this data. This information will not be used for underwriting purposes or to determine the coverage of your benefits and/or services.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with:

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711) Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Service.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans *(cont'd)*

We must ensure that you get timely access to your covered services and drugs.

As a member of our plan, you have the right to choose a primary care physician (PCP) in the plan's network to provide and arrange for your covered services. Call Customer Service to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, please refer to Chapter 9, Section 10 of the EOC for details on what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

We must protect your privacy.

Federal and state laws protect the privacy of your medical records and protected health information. We protect your protected health information as required by these laws.

Your "protected health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice" that tells about these rights and explains how we protect the privacy of your health information.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans *(cont'd)*

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These following exceptions are allowed or required by law:
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your protected health information, please call Customer Service.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans *(cont'd)*

We are always committed to protecting the privacy of your personal and health information. Our Notice of Privacy Practices describes both your privacy rights as a member and how we protect your personal and health information. To obtain a copy of our privacy notice, you can:

1. Go to www.blueshieldca.com and click the *Privacy* link at the bottom of the homepage and print a copy.
2. Call the Customer Service phone number on your Blue Shield member ID card to request a copy.
3. Call the Blue Shield of California Privacy Office toll-free at (888) 266-8080 (TTY 711), 8 a.m. to 3 p.m., Monday through Friday.
4. Email us at privacy@blueshieldca.com

We must give you information about the plan, its network of providers, and your covered services.

As a member of Blue Shield 65 Plus, you have the right to get information from us in a way that works for you, including getting the information in languages other than English, in large print, or other alternate formats, such as:

- Information about our plan. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's Star ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- Information about our network providers including our network pharmacies.
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the Provider Directory.
    - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
    - For more detailed information about our providers or pharmacies, you can call Customer Service or visit our website at www.blueshieldca.com/fad/home.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans *(cont'd)*

- Information about your coverage and the rules you must follow when using your coverage.
    - In Chapters 3 and 4 of the EOC we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of the EOC plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
    - If you have questions about the rules or restrictions, please call Customer Service.
- Information about why something is not covered and what you can do about it.
    - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
    - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of the EOC. It gives you the details how to make an appeal if you want us to change our decision. (Chapter 9 in the EOC also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
    - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of the EOC.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans *(cont'd)*

We must support your right to make decisions about your care.

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choice**s. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of the EOC explains how to ask the plan for a coverage decision.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans *(cont'd.)*

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **"advance directives."** There are different types of advance directives and different names for them. Documents called **"living will"** and **"power of attorney for health care"** are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans *(cont'd.)*

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with Livanta. See Chapter 2, Section 4 of the EOC for contact information.

You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, Chapter 9 of the EOC tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service.

What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at (800) 368-1019, TTY (800) 537-7697, or call your local Office for Civil Rights.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans *(cont'd.)*

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call **Customer Service.**
- You can call the **State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to Chapter 2, Section 3, or
- You can call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How to get more information about your rights.

There are several places where you can get more information about your rights:

- You can call **Customer Service**.
- You can call the **SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare.**
    - You can read or download the publication *Medicare Rights & Protections* at the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf, or
    - You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You have some responsibilities as a member of the plan

What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service. We're here to help.

Get familiar with your covered services and the rules you must follow to get these covered services. Use the EOC to learn what is covered for you and the rules you need to follow to get your covered services.

- Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans *(cont'd.)*

If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Customer Service to let us know.

- We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)

Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.

Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.

- To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

Pay what you owe. As a plan member, you are responsible for these payments:

- In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.

Member Rights and Responsibilities – Blue Shield Medicare Advantage Plans *(cont'd.)*

- For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
    - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

Tell us if you move. If you are going to move, it's important to tell us right away. Call Customer Service.

- **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
- **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

Call Customer Service for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.

- Phone numbers and calling hours for Customer are printed on the back cover of this booklet.
- For more information on how to reach us, including our mailing address, please see Chapter 2.

Member Grievance Process

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

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

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

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

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

Member Grievance Process *(cont'd.)*

Definitions

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

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

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

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

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

Member Grievance Process *(cont'd.)*

Blue Shield Commercial Policy

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

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

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

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

Blue Shield Medicare Advantage Plan Policy

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

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

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

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

Member Grievance Process *(cont'd.)*

Blue Shield Medicare Advantage Plan Policy *(cont'd.)*

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

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

Standard Review Process

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

Expedited Review

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

Member Grievance Process *(cont'd.)*

Expedited Review *(cont'd.)*

The Blue Shield grievance process allows members to file grievances within 180 days following any incident or action that is the subject of the enrollee's dissatisfaction.

External Review

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

External Exception Review

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

Contacting the Appeals and Grievance Department

To contact the Appeals and Grievance Department, please refer to the *Contact us* section at the top of Provider Connection at www.blueshieldca.com/provider.

Fraud Prevention

Each year hundreds of millions of dollars are lost due to health care fraud, waste, and abuse. The mission of the Blue Shield Special Investigations Unit (SIU) is to ensure we provide the best investigative services for the company and stakeholders by being nimble and highly responsive to a broad spectrum of suspected fraudulent activities. The SIU is accountable for leading investigations and criminal/civil prosecutions of internal and external entities and is the primary liaison with all levels of law enforcement. In conjunction, the SIU coordinates efforts to recover erroneous payments, misrepresentative billing, fraud, abuse, or other acts resulting in overpayments.

Providers can help us to stop this pervasive problem by reporting suspicious incidents. To learn more, as well as how and what to report, go to www.blueshieldca.com, click on the *About Blue Shield* link at the bottom, and then the *Preventing fraud*. Here, providers can get guidance related to billing practices and prevention of inappropriate practices. Investigators in the (SIU) research suspicious billing practices.

Providers can also email Special Investigations directly at stopfraud@blueshieldca.com, or call Blue Shield's 24-hour Fraud hotline at the toll-free telephone number (855) 296-9092. Callers and emailers may remain anonymous, if desired.

Provider Audits

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

Audits are also conducted to ensure compliance with:

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

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

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

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

Fraud Prevention *(cont'd.)*

Fraud, Waste, and Abuse

The Medicare Prescription Drug benefit was implemented by the Centers for Medicare & Medicaid Services (CMS) to allow all Medicare beneficiaries access to prescription drug coverage. In its effort to combat fraud in the Medicare prescription drug program, CMS has added several Medicare Drug Integrity Contractors (MEDICs). In California, the MEDIC is Qlarant Integrity Solutions, LLC. Qlarant Integrity Solutions, LLC is responsible for monitoring fraud, waste, or abuse in the Medicare Part C and Part D programs on a national level.

Qlarant Integrity Solutions, LLC has been authorized by CMS to monitor Medicare fraud, waste, and abuse and to investigate any beneficiary complaints related to Medicare Part C and D benefits.

Qlarant Integrity Solutions, LLC is interested in receiving reports of potential fraud, waste, or abuse from Medicare beneficiaries. Examples of these types of complaints may include:

- An individual or organization pretends to represent Medicare and/or Social Security, and asks the beneficiary for their Medicare or Social Security number, bank account number, credit card number, money, etc.
    - Someone asks the beneficiary to sell their Medicare ID card.
    - Someone asks the beneficiary to get drugs or medical services for them using their Medicare ID card.

Fraud Prevention *(cont'd.)*

Fraud, Waste, and Abuse *(cont'd.)*

- The beneficiary feels a Medicare Advantage or standalone Part D plan has discriminated against them, including not letting them sign up for a specific plan because of their age, health, race, religion, or income.
    - The beneficiary was encouraged to disenroll from their current health plan.
    - The beneficiary was offered cash to sign up for a Medicare Advantage or standalone Part D plan.
    - The beneficiary was offered a gift worth more than $15 to sign up for a Medicare Advantage or standalone Part D plan.
    - The beneficiary's pharmacy did not give them all of their drugs.
    - The beneficiary was billed for drugs or medical services that he/she didn't receive.
    - The beneficiary believes that he/she was charged more than once for their premium costs.
    - The beneficiary's Medicare Advantage or standalone Part D plan did not pay for covered drugs or services.
    - The beneficiary received a different Part D drug than their doctor ordered.

Medicare beneficiaries should contact Qlarant Integrity Solutions, LLC at (877) 772-3379 to report complaints about any of these types of fraud, waste, and abuse issues or a related complaint. Qlarant Integrity Solutions, LLC may also be contacted by fax at (410) 819-8698 or on their website at www.qlarant.com/wp-content/uploads/2020/11/Qlarant_I-MEDIC_Complaint_Form_2020_11_04.pdf . Reports may also be submitted directly to Blue Shield of California's Special Investigations Unit at (855) 296-9092, via email at stopfraud@blueshieldca.com, or through the Medicare Compliance Department at (855) 296-9084.

Fraud Prevention *(cont'd.)*

Medicare Compliance and Fraud, Waste, and Abuse Training Requirements

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

Blue Shield requires all First-Tier, Downstream, and Related Entities (FDRs), including but not limited to IPAs, medical groups, providers, independent sales agents, third party marketing organizations (TMOs), and contracted pharmacies who work works with the Medicare Program that they successfully complete a fraud waste and abuse (FWA) training. This training should focus on how to detect, correct, and prevent non-compliance and fraud, waste, and abuse surrounding Medicare programs.

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

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

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

Blue Shield's Code of Conduct and Corporate Compliance Program

Blue Shield of California is guided by our North Star: To create a healthcare system that is worthy of our family and friends and sustainably affordable. We have deeply held values that also guide us and the experiences we create – for our members, our partners, our communities, ourselves, and others.

Objectives:

1. To strengthen and sustain a corporate culture of compliance, ethics, and integrity.
2. To prevent, detect and remediate unlawful or unethical conduct.
3. To create, strengthen and sustain an environment that facilitates the reporting of actual or suspected violations of law, company policies, Code of Conduct, and other misconduct, without fear of retaliation.

Blue Shield's Code of Conduct (Code) is the written expression of our expectations, requiring compliance with the law and our policies, and helping us keep sight of our values and translate them into everyday actions. At Blue Shield, we recognize that to lead with integrity, we must do what's right for our members and our company in every action, every transaction, every conversation.

The Code cannot cover every detail of every rule or law that applies, but the Code is always the best place to start. It gives providers a high-level view of important topics and points you to other resources. We are honored to do business with partners that support our mission.

Providers can make confidential reports of concerns or report actual or potential violations via the Compliance & Ethics Hot Line at (855) 296-9083. If providers have additional questions about this program, please contact Provider Information & Enrollment at (800) 258-3091.

To view Blue Shield's Code of Conduct, navigate to Blue Shield of California Code of Conduct.

Privacy and Security

The Privacy Office provides oversight of Blue Shield's compliance with state, federal, and international privacy laws, including the privacy components of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

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

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

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

Privacy and Security Risks of Medical Devices

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

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

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

Blue Shield Medicare Advantage Program Overview

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

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

The Blue Shield Medicare Advantage HMO plans provides comprehensive coordinated medical services to members through an established provider network. Similar to the commercial HMO product, Blue Shield Medicare Advantage plan members must choose a primary care physician (PCP) and have all care coordinated through this physician.

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

Blue Shield Medicare Advantage Compliance Program

The Medicare Modernization Act (MMA) established the Medicare Advantage (MA) Program, building on the prior compliance requirements for health plans contracted under the Medicare program. The MMA added Medicare Part D and new coverage for prescription drugs and continued to build on the program integrity provisions in the Balanced Budget Act of 1997. Medicare Advantage Organizations and Part D Sponsors are required by CMS to possess a compliance program through which the organization establishes and maintains compliance with all federal and state standards. Moreover, provisions in the Affordable Care Act (ACA) require that the compliance program be "effective" in preventing and correcting non-compliance with Medicare Program requirements and fraud, waste, and abuse.

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

The compliance program must include:

- Written policies, procedures, and standards of conduct
- Compliance Officer, Compliance Committee, and high level oversight
- Effective training and education
- Effective lines of communication
- Well publicized disciplinary actions
- Effective system for routine monitoring, auditing, and identification of compliance risks
- Procedures and system for prompt response to compliance issues

Blue Shield's Corporate Compliance Program includes four primary components:

- Model policies for employee, officer, and director conduct
- Code of business conduct
- Toll-free hotline for reporting actual or suspected violations
- Special investigations team for fraud and abuse reviews

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

While the existing Corporate Compliance Program remains the foundation for our organizational compliance, a separate compliance structure was established for the Medicare Advantage Program and the Medicare Part D Programs. Medicare Compliance is supported by a dedicated team. Under the oversight of Blue Shield's Vice President, Chief Compliance & Ethics Officer, the Medicare Compliance Department handles communication with CMS and the Blue Shield operating departments regarding the Medicare plans. A dedicated team headed by the Medicare Compliance Officer advises about CMS requirements and monitors compliance within the organization and in relation to Blue Shield's representatives in the community. The Medicare Compliance Officer leads the day-to-day operations of the Medicare Compliance functions and reports directly to the VP, Chief Compliance & Ethics Officer, who provides direct and periodic reports to Blue Shield's Board of Directors (Audit Committee), the company's Chief Executive Officer (CEO) and senior management on relevant Medicare Compliance and other Corporate Compliance issues, as appropriate.

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

The Medicare Compliance Department builds on components of our Corporate Compliance & Ethics Program and Code of Conduct, and the work of the Privacy Office, which is responsible for the oversight of Blue Shield's compliance with state and federal privacy laws, including the privacy components of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

The Medicare Compliance Officer chairs the Plan's Medicare Compliance Committee, which has representation from all areas of the company that touch the Medicare programs. The Committee serves as the forum for program direction and oversight relative to operating requirements, performance measures and the definition and implementation of effective corrective actions, when indicated. The Medicare Compliance Committee, and Medicare Compliance Department staff, as well as the Blue Shield team of internal auditors, validates the continuing compliant operations of functional areas within the company and the compliant performance of contractors and agents through:

- Monitoring, auditing performance and regulatory compliance
- Auditing of delegated and downstream providers' compliant execution responsibilities
- Monitoring of corrective actions imposed by internal and external entities
- Training and education of employees, temporary employees, and contracted providers and agents in Medicare program requirements and Blue Shield policies on privacy, compliance, fraud, waste, and abuse detection and reporting.
- Tracking of changes in CMS requirements and educating operating units, accordingly
- Verifying current written policies and procedures
- Tracking and submission of required certifications and reporting to CMS

The Medicare Compliance Program sets the framework for our oversight vision and processes and lays out monitoring programs and activities relative to our overall compliance with CMS regulatory requirements. It is our expectation that the Medicare Compliance Program will not only enable Blue Shield to meet increasing CMS requirements, but also to improve the quality of care and service provided to our Medicare Advantage and Medicare Part D members. The overall compliance structure incorporates the Code of Conduct and the Compliance Program to promote ethical behavior, equal opportunity, and anonymity in reporting of any improprieties within the Medicare product or elsewhere within the organization. Blue Shield has and enforces a strict non-retaliation policy for reporting actual or suspected legal, policy or Code violations, or any other misconduct, in good faith.

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

Key compliance indicators or benchmarks, as well as concerns raised through internal and external monitoring activities, are reviewed by the Medicare Compliance Committee to help proactively identify potential issues and facilitate internal corrective actions or policy changes, as indicated. These elements of the Blue Shield Medicare Compliance Program provide examples of policies and programs that providers might wish to establish within their own organizations.

Auditing and Monitoring

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

Confirmation of Eligibility of Participation in the Medicare Program

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

- www.oig.hhs.gov/exclusions/exclusions_list.asp
- www.sam.gov/content/home

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

Healthcare Regulatory Agencies

California Department of Insurance (CDI)

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

California Department of Managed Health Care (DMHC)

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If the member has a grievance against Blue Shield, the member should first telephone Blue Shield at the number provided in their *Evidence of Coverage* booklet to use the grievance process before contacting the DMHC. Utilizing Blue Shield's grievance process does not prohibit any potential legal rights or remedies that may be available to the member. If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Blue Shield, or a grievance that has remained unresolved for more than 30 days, the member may call the DMHC for assistance. The member may also be eligible for an Independent Medical Review (IMR). If they are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by Blue Shield related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

Providers can reach the DMHC at (888) 466-2219, TDD line (877) 688-9891 for the hearing and speech impaired, or through www.dmhc.ca.gov, where complaint forms, IMR application forms, and instructions can be found. A revised IMR form is available in English and the 16 threshold languages on the DMHC website at www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx.

Healthcare Regulatory Agencies *(cont'd)*

Centers for Medicare & Medicaid Services (CMS)

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

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

This page intentionally left blank.

Section 2: Hospital and Facility Responsibilities

This page intentionally left blank.

Table of Contents

This page intentionally left blank.

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 according to Blue Shield's 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

Accreditation

Blue Shield maintains Health Plan Accreditation (HPA) with National Committee for Quality Assurance (NCQA). Blue Shield of California'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.

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

Provider Responsibilities for Quality Management and Improvement

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

- QI Committees
- Credentialing, peer review and utilization management determinations, and utilization management
- Clinical QI workgroups
- F~~o~~cus groups
- QI studies
- Investigation of member grievances and quality of care issues

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

All affiliated Hospitals are expected to perform higher than 50% of benchmark for CMS Hospital Compare/CAL Hospital Compare. All affiliated hospitals that perform less than 50% of the benchmark for CMS Hospital Compare/CAL Hospital Compare will be required to submit an improvement plan of action for the identified performance year.

To comply with NCQA accreditation requirements, Blue Shield collects and reports HEDIS data as it relates to Blue Shield members. Blue Shield HMO-contracted physicians and hospitals are required to provide medical records requested for HEDIS data collection within the defined time period. HIPAA includes data collection for HEDIS reporting in the category of health care operations, thus no special patient consent or authorization is required to release this information.

Quality management activities are considered privileged communication in conjunction with peer review activities conforming to Evidence Code Section 1157 and Section 1370 of the California Health and Safety Code.

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

Submission of Laboratory Results Data

All hospitals contracting with Blue Shield 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), chronic condition management programs, and other similar activities.

Results for laboratory tests (analyses) 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. Coding for analytes must use the LOINC coding system. Blue Shield subscriber and member IDs must be used in each record. Data must be submitted on a monthly basis using Blue Shield's secure data exchange procedures.

Contact the HEDIS Supplemental data team at HEDISSUPPDATA@Blueshieldca.com for additional details and requirements, as well as to initiate required submissions of laboratory results data.

Reporting Specified C-Section Rates

To comply with Covered California requirements, hospitals must report, quarterly or on a bi-annual basis, to the Maternal Data Center of the California Maternal Quality Care Collaborative the number of nulliparous women with a term, singleton baby in a vertex position (NTSV) delivered by cesarean section.

- Numerator: uncomplicated C-sections MS-DRG 766
- Denominator: all born MS-DRGs 765, 766, 767, 768, 774, 775
- Exclusions:
    - CD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations and other presentations as defined in Appendix A, Table 11.09
    - Less than 8 years of age
    - Greater than or equal to 65 years of age
    - Length of Stay >120 days
    - Enrolled in clinical trials
    - Gestational Age < 37 weeks or UTD

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

Reporting Hospital-Acquired Conditions to CMS

To comply with the Centers for Medicare & Medicaid Services (CMS) and Covered California requirements, hospitals must report to Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) quarterly rates of hospital-acquired conditions (HACs) specified below using CDC's reporting criteria at www.cdc.gov/nhsn/cms/index.html.

- Methicillin-resistant Staphylococcus aureus (MRSA)
- Catheter-associated Urinary Tract Infection (CAUTI)
- Central Line-associated Bloodstream Infection (CLABSI)
- Colorectal Surgical Site Infection (SSI Colon)
- Clostridium difficile Infection (CDI)

Blue Shield is actively working towards improvement of Hospital Acquired Conditions for all contracted hospitals. In order to comply with Covered California's requirements that all hospitals achieve infection rates (measured as a standardized infection ration or SIR) of 1.0 or lower, Blue Shield may reserve the right to promote hospital involvement in a performance improvement plan for Hospitals performing in the bottom quartile.

Patient Safety

Blue Shield is committed to improving the safety of clinical practice by fostering an environment in which all parties are attentive to safety issues. Blue Shield supports our network providers by identifying patient safety opportunities. We also endorse statewide collaborative activities and encourage hospitals to participate in the following programs:

- The Blue Distinction® Program
  www.bcbs.com/healthcare-partners/blue-distinction-for-providers/
- Cal Hospital Compare
  www.calhospitalcompare.org
- The California Maternal Quality Care Collaborative
  www.cmqcc.org
- The Leapfrog Hospital Survey
  www.leapfroggroup.org/survey-materials

Blue Shield has incorporated safety-related information and on-line consumer decision support tools to promote informed consumer decision making at the point of care.

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

Patient Safety *(cont'd.)*

We take an active role in supporting and improving patient safety through a variety of activities including:

- Promoting continuity and coordination of care between practitioners and between care settings.
- Member education regarding preparation for surgery and post-surgical care.
- Designation of centers of excellence for complex, high-risk procedures.
- Comprehensive Case Management program to improve medication treatment plan adherence.
- Focused utilization management to improve readmission rates and bed day utilization.
- Careful evaluation of new medical procedures and medications, utilizing evidence-based literature, and seeking input from academically acknowledged medical authorities.
- "Alert" messages for physicians and patients regarding clinical compliance with well-accepted practice guidelines.
- Ongoing assessment and evaluation of hospital safety, utilization, patient experience, and quality performance. To include, but not limited to, quarterly performance reviews, implementation of action and improvement plans, and technical assistance for specific hospital quality domains.

Quality of Care Reviews

Blue Shield has a comprehensive review system to address potential quality of care issues. A potential 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. 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 the involved facility. Upon review completion, dependent upon the severity of any quality findings identified, follow-up actions may be taken to include a request for corrective action or an educational letter. Patient safety concerns and/or patterns of poor care are considered during Blue Shield recredentialing activities or reviewed in more detail by the Blue Shield Credentialing Committee.

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

Contracted facilities 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. As such, neither the proceedings nor record of the review may be disclosed outside of the review process.

Medical Records

To assist us in maintaining continuity of care, hospitals must provide medical records of services rendered to Blue Shield members when it is essential to communicate the documentation of care to other providers and/or Blue Shield for the purpose of delivering further care and/or making further care decisions.

Members are entitled to obtain copies of their own medical records, including copies of emergency department records, X-rays, CT scans, and MRIs. Hospitals must make member medical records available upon request within time requirements established by regulatory agencies, to the member, and to Blue Shield and its designated agents. Additionally, the hospital must, without charge, transmit a member's medical record information to the member's primary care physician and other providers, to government officials, and to Blue Shield for purposes of utilization management, quality improvement, and other Blue Shield administrative purposes. The hospital also must secure from the member on admission a release of medical information, in the event it is required by law.

Hospitals must maintain an individual, continuous unit record for each member and document on an ongoing basis when a member is seen in the facility with all pertinent information recorded in a legible manner. The medical record must document care provided in the facility, as well as referrals and follow-up to referrals for care outside of the hospital. Allergies must be noted in a prominent place in the medical record, as well as the existence or absence of an executed Advance Directive.

Hospitals shall maintain the usual and customary records for Blue Shield members in the same manner as for other hospital patients and require that all physicians treating members at the facility establish and maintain, in an accurate and timely manner, an organized medical record. It should contain the demographic and clinical information necessary to document the member's medical problems and the medical services he or she receives.

The medical record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or provided under the direction of, the hospital. The record shall be in a form that allows trained health professionals, other than the hospital, to readily determine the nature and extent of the member's medical condition and which services were provided and that allows peer review of the care provided.

In keeping with regulatory standards, a member's medical records must be kept for at least 10 years after the last member contact.

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

Sensitive Health Information

Under California's existing Reproductive Privacy Act and the Confidentiality of Medical Information Act (CMIA), individuals have a fundamental right to privacy regarding their reproductive/medical decisions. Unauthorized disclosure of medical information is generally prohibited. California Assembly Bill 352 (AB 352) introduced significant changes to how Health Insurance Companies, Managed Health Care Organizations and their downstream/related entities are required to handle sensitive health information, including but not limited to reproductive health, abortion, and transgender services.

AB 352 expands the previously existing privacy requirements, specifying that on or before July 1, 2024, electronic health record (EHR) systems that store such information are required to adhere to additional provisions regarding medical information related to gender-affirming care, abortion and abortion-related services, and contraception ("sensitive services").

Specifically, EHR systems that collect and store data on behalf of providers and other organizations are required to:

- Ensure limited user access to all medical information, such that specific medical information related to sensitive services is only accessible to the parties that are authorized to access that specific information.
- Prevent disclosure, access, transfer, transmission, or processing of sensitive services medical information to any person or entities outside of California.
- Segregate and differentiate any medical information related to sensitive services in a patient's record.
- Automatically disable access to any segregated medical information related to sensitive services by individuals and entities in any other state.

By law, Blue Shield of California/Blue Shield Life & Health insurance Company and providers must comply with these requirements. As such, Blue Shield expects that providers have systems and processes in place to address data sharing/disclosure requirements.

Advance Directives

An Advance Directive (also known as a Durable Power of Attorney for Healthcare) is a formal document completed by an individual in advance of an incapacitating illness or injury. When the individual becomes too ill to communicate his or her wishes concerning medical care, providers use the directive as guidance in providing treatment. Blue Shield recommends that all Medicare members and any member 18 and older have a signed Advance Directive communicating their wishes regarding health care decisions to their physician and family members.

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 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

CATEGORY	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

Section 2: Hospital and Facility Responsibilities

CATEGORY	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.
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	STANDARD
Care for an Emergent Non-Life-Threatening Situation	Within 6 hours
Urgent Care visits	Within 48 hours
Initial routine visits with non-physician practitioners, substance use disorder providers, and behavioral health physicians	Within 10 business days
Routine and follow-up visits with non-physician practitioners and substance use disorder practitioners	Within 10 business days
Routine and follow-up visits with behavioral health physicians	Within 15 business days

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 (PCPs), high-volume and high-impact specialty practitioners that is sufficient in number and geographic distribution for applicable commercial products. Please refer to the provider availability standards below.

Section 2: Hospital and Facility Responsibilities

Geographic Distribution

CATEGORY	PRODUCT TYPE	STANDARD	COMPLIANCE TARGET
Total PCPs	HMO/POS PPO - CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	One PCP within 15 miles or 30 minutes of each member (DMHC Regulated)	100%
PCP **General Practitioner** **Family Practitioner** **Internist** **Pediatrician**		One PCP of each type within 15 miles or 30 minutes of each member (NCQA)	90%
Obstetrician/Gynecologist		One OB/GYN within 30 miles of each member (including Medicare)	85%
High-Volume Specialists **High-Impact Specialists**		One High-Volume Specialists of each type and one High-Impact Specialists of each type within 30 miles of each member	90%
Hospitals		One hospital within 15 miles of each member (non-Medicare)	100%
Radiology		One Radiology facility in 30 miles	90%
Lab		One lab in 30 miles	90%
Pharmacy		One Pharmacy in 15 miles	90%
DME		One DME in 15 miles	85%
ASC		One ASC in 30 miles	95%
SNF		One SNF in 30 miles	95%
Urgent Care		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: I in 30 miles	90% 85% 75%
Dialysis		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: I in 30 miles	90% 85% 75%
Acupuncturist and Chiropractor	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.	90%

Behavioral Health Geographic Access Standards

CATEGORY	STANDARD	COMPLIANCE TARGET
Geographic Distribution of Behavioral Health Individual Practitioners including: Psychiatrists, Psychologists, Master's Level Therapists, Substance Use Disorder Practitioners	Urban: 1 practitioner of each type within 10 miles of each member Suburban: 1 practitioner of each type within 20 miles of each member Rural: 1 practitioner of each type within 30 miles of each member	Urban: 90% Suburban: 85% Rural: 75%
Geographic Distribution of Behavioral Health Facilities including: Inpatient Psychiatric Hospital, Residential and OP Treatment Facilities	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: High-Volume Specialties including Substance Use Disorder practitioners	1 provider of each type (i.e., Psychologists, Psychiatrists, or Master's Level Therapists) to 10,000 members	100%

Provider-to-Member Ratio

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
Total PCPs	HMO/POS PPO – CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	1 PCP to 2,000 commercial members	100%
PCP Family Practitioner, General Practitioner, Internist Pediatrician	HMO/POS PPO – CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	1 PCP of each type to 2,000 commercial members	100%
Top High-Volume Specialties and High-Impact Specialties to Member Ratio	HMO/POS PPO – CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	1 OB/GYN to 5,000 female members. 1 High-Volume Specialty of each type and 1 High-Impact Specialty of each type to 10,000 members.	100%
Acupuncturist to Member Ratio	PPO	1 Acupuncturist to 5,000 commercial members	100%

Section 2: Hospital and Facility Responsibilities

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
Language Needs	HMO/POS PPO – CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	1 PCP speaking a threshold language to 1,200 members speaking a threshold language	100%
The number of Non-Physician Medical Practitioners (NPMPs) does not exceed four in any combination. The supervising physician holds ultimate responsibility for the practice of each supervised NPMP. The one to four ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more NPMPs than can be supervised within the limit.	HMO/POS PPO – CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	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.	100%

*PPO plans are both Blue Shield PPO – DMHC and PPO – CDI plans. PPO membership excludes ASO/self-insured business.

Provider Availability Standards for Medicare Advantage Products

Linguistic and Cultural Requirements

CATEGORY	PRODUCT	STANDARD	COMPLIANCE TARGET
PCP providers with linguistic capacity	HMO/POS PPO - DMHC	1 PCP speaking a threshold language to 1,200 members speaking a threshold language	100%

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

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.)*

Provider Minimum Number Requirements *(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 a Blue Shield PPO provider 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.

Additional Measurements for Multidimensional Analysis for Commercial Products

METRICS	PRODUCT	STANDARD	FREQUENCY
Access and availability 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 Quarterly against Standard
Availability-related PCP Transfers	HMO	Rate of PCP transfers 1.68 per thousand members per month (Medicare)	Assessed Quarterly against Standard
PCP Turnover	HMO/POS	10% change	Assessed Quarterly against Standard
PCP, Specialist, and Hospital Network Change Analysis	IFP ePPO	10% change	Assessed Quarterly against Standard
PCP to Member Ratio	IFP PPO	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	70%	Assessed Annually against Standard
Member Satisfaction	HMO/POS/PPO	HMO – Patient Assessment Survey at IPA/MG level HMP/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
PCP Turnover Rate	10%	Semi-Annual
Top 10 HVS Turnover Rate	10%	Semi-Annual
Hospital Turnover Rate	5%	Semi-Annual
Open PCP Panels	70%	Semi-Annual
PCP to Member Assignment Ratio	1: 1200	Semi-Annual
High-Volume and High-Impact Specialist to Member Ratio	1:20,000	Annual

Language Assistance for Persons with Limited English Proficiency (LEP)

Blue Shield does not delegate overall responsibility for culturally and linguistically appropriate services to contracted providers unless otherwise noted in their agreement with Blue Shield. This section summarizes Blue Shield's Language Assistance Program (LAP) and specifies the roles and responsibilities of Blue Shield and its contracted hospitals in supporting the program.

Blue Shield's Language Assistance Program

Blue Shield is committed to providing quality health care services to all enrollees regardless of their ability to speak English. Providing services that support diverse languages is one-way Blue Shield addresses some barriers to accessible health care. We provide documents and telephonic support in various languages to improve access to healthcare services for our shared members. Additionally, we provide language assistance resources for easy download on our website, such as a multilingual sign for your office and member forms already translated into the designed member's threshold language.

Blue Shield and its contracted providers must offer timely language assistance services to its LEP enrollees at all points of contact where the need for such services can be reasonably anticipated, and at no charge to the enrollee, even when the enrollee is accompanied by a family member or friend who can interpret.

To request interpreter services, written language translation, or our provider notice of availability of language assistance services, please call our Provider Customer Service at (800)-541-6652 or visit our Language Assistance Program Resources webpage at www.blueshieldca.com/en/provider/guidelines-resources/patient-care-resources/language-assistance.

Blue Shield's Demographics and Language Services

Blue Shield may share individual patient demographics, which include language data, directly with providers. We share member data on the service area population for the top threshold languages and the U.S. Census data for the state of California to bring awareness of the needs of our members.

California population language data from the United States Census can be accessed online at www.census.gov/quickfacts/facts/table/CA/PST045221

Blue Shield's Commercial/Exchange threshold languages are:

- English
- Spanish
- Chinese – Traditional
- Korean
- Vietnamese

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Blue Shield's Demographics and Language Services *(cont'd.)*

Blue Shield's Medicare threshold language are:

- Contract H0504 all Plan Benefit Packages (PBPs): English & Spanish
- Contract H5928 all PBPs: English & Spanish
- Contract H4937 PBP 001: English, Spanish & Chinese
- Contract H4937 PBP 002: English & Spanish
- Contract H2819 PBP 002 and 003: English & Spanish
- Contract H2819 PBP 001: English, Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Spanish, Tagalog, Vietnamese

A threshold language is a language other than English that Blue Shield will use to translate required documents. For Medicare, CMS has "required" materials which are listed in CFR § 422.2267 *Required materials and content*. Threshold languages are determined based on the language preferences of the largest number of plan enrollees, excluding Medi-Cal, Medicare and Administrative Services Only enrollees. For Medicare Advantage plans, CMS sets the required threshold languages at 5%.

Identifying LEP Enrollees at Points of Contact

When an enrollee communicates their language preference to Blue Shield, it is added to the enrollee's profile and printed on their member identification card if it is a language other than English.

Hospitals must inform Blue Shield LEP enrollees who have a language preference other than English that the hospital provides access to interpretation services at no cost to the enrollee.

Providing Interpretation Services at Points of Contact

Blue Shield representatives have access to telephonic interpretation services to provide timely interpretive services in other languages. Blue Shield may employ Customer Service Representatives who are multi-lingual and demonstrate proficiency in the non-English language to assist non-English-speaking LEP members. Hospitals are required to provide interpretation services. Therefore, when Blue Shield enrollees request assistance directly from hospital staff, the hospital is responsible for making arrangements and for any associated cost. Regulations require that Blue Shield monitor contracted facilities for deficiencies in the delivery of interpretation services. Where language or communication barriers exist between patients and staff of any general acute care hospital or facility, arrangements must be made for professional staff members that are bilingual to ensure adequate and speedy communication between patients and staff.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Timeliness Standards for Interpretation Services at Points of Contact

For purposes of this subsection, "timely" means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if they delay results in the effective denial of the service, benefit, or right at issue. Quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, including standards for coordinating interpretation services with appointment scheduling, are:

- **Over-the-Phone Interpretation (OPI):** Immediate – no more than 10 minutes, from time of connection with the interpretation vendor to the time that the interpreter (who speaks the enrollee's language) is present on the telephone line.

  Used for administrative points of contact with Blue Shield, and routine, urgent and emergent services with contracted hospitals.
- **In-Person Interpretation (IPI), or Face-to-Face Routine Visit:** Five (5) business days with advanced notice from the enrollee is preferred in order to make best efforts to accommodate the request for face-to-face interpreters. At the time of the appointment, if a face-to-face interpreter has been scheduled and the interpreter does not show after a 15-minute wait time, hospital staff shall offer the enrollee the choice of using a telephone interpreter or the opportunity to reschedule the appointment.
- **For appointments made within 48 hours/Emergency** (same or next day access for routine or urgent care): Provide services telephonically (see *Over-the-Phone Interpretation* above).

These standards also apply when the enrollee contacts Blue Shield to arrange for an interpreter.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Documenting Enrollee Refusal of Language Assistance

If the enrollee refuses language assistance services offered when contacting Blue Shield, it will be documented in the enrollee's record. If the enrollee declines language assistance services offered by a Blue Shield contracted hospital, the hospital staff is required to document the refusal in the enrollee's medical record.

Documenting that a patient has refused interpretive services in the medical record is a way to protect hospitals. It will ensure consistency when medical records are monitored through site reviews or audits. If the patient insists on using a family member or friend to interpret, hospital staff must also note that in the medical record. It is especially important to document if the interpreter used is a minor. Consider offering a professional telephonic interpreter through the telephonic interpretation service, in addition to a patient's chosen family member or friend, to ensure accuracy of the interpretation.

In emergency situations, a minor may be used as an interpreter if the following conditions are met:

(A) The minor demonstrates the ability to interpret complex medical information in an emergency/critical situation; and,

(B) The insured is fully informed in his or her primary/preferred spoken language that a qualified interpreter is available at no charge to the insured. If the insured refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the insured's decision to use the minor as the interpreter shall be documented in the medical record file.

It is required that hospital staff document in the patient's medical record an LEP patient's preferred language. Additionally, it is recommended the medical record also contain the name and contact information of any professionally-trained interpreter whose services were used for a medical visit.

Informing Enrollees of their Right to Appeal

Blue Shield provides enrollees with written notices in their language, provided that it is one of Blue Shield's threshold languages, informing them about their right to file an appeal with the plan or seek independent medical review (IMR).

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Informing Enrollees of their Right to Appeal *(cont'd.)*

These notices are available for hospitals on Provider Connection at www.blueshieldca.com/provider under *Guidelines & resources, Patient care resources*, and then *Language Assistance Program*. Members may access appeal and IMR information in their *Evidence of Coverage* or *Certificate of Insurance*, and at blueshieldca.com, as well as the DMHC website at www.dmhc.ca.gov or on the CDI website at www.Insurance.ca.gov. Hard copies of the DMHC notice may also be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814. A revised Independent Medical Review/Complaint Form is available in English and the 16 threshold languages on DMHC website at Independent Medical Review/Complaint Forms.

Providing Translation Services

Vital Documents

Vital documents are materials deemed critical to accessing the health plan and its benefits. Vital documents may be produced by the plan, a contracted health care service provider, or contracted administrative services provider.

The following documents are the "vital documents" produced by Blue Shield. This category includes documents produced or distributed to enrollees by a delegated IPA or medical group:

- Applications
- Consent forms, including any form by which a member authorizes or consents to any action by Blue Shield
- Letters containing important information regarding eligibility and participation criteria
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal
- Notices advising LEP enrollees of the availability of language assistance at no cost and other outreach materials that are provided to enrollees
- Blue Shield's and delegated IPA/medical group explanation of benefits or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee
- Enrollee disclosures (Benefit Matrix or Patient Charge Schedules).

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Vital documents are divided into two categories:

- **Standard Vital Documents**
  Most standard documents are translated up front, while other standard vital documents such as Summary of Benefits Coverage, benefit summaries and benefit matrices will be translated upon request by LEP enrollees.
- **Non-Standard Vital Documents**
  Non-standard vital documents contain enrollee-specific information. These documents are not translated into threshold languages. Blue Shield will include with any non-standard vital documents distributed to enrollees the appropriate DMHC/CDI-approved written notice of the availability of interpretation and translation services. If translation or interpretation of any non-standard vital document is requested by the enrollee, Blue Shield will provide the requested translation within 21 calendar days of that request, with the exception of expedited grievances, as noted below.

Blue Shield's Standard Vital Documents

Blue Shield has identified its standard vital documents (i.e., documents that do not contain enrollee-specific information) and has translated these documents into its threshold languages. Examples of standard vital documents include:

- Applications, consent forms
- Notices of the right to file a grievance or appeal
- Notice of language assistance at no cost

Blue Shield's Non-Standard Vital Documents

Blue Shield has identified documents that contain enrollee-specific information and has translated these documents into its threshold languages. Examples of non-standard vital documents include:

- Letters containing important information regarding eligibility and participation criteria;
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Notice of the Availability of Language Assistance Services

Blue Shield issues non-standard vital documents to all enrollees and includes brief, alternate instructions in English and our threshold languages, as follows:

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码 1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwijį' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերենլեզվովանվճարօգնությունստանալուհամարխնդրում ենքզանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合 1-866-346-7198 に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (پنجابی):- پنجابی وچ مدد لئی مہربانی کر کے 1-866-346-7198 تے مفت کال کرو

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198.

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا ، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।.

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198.

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Notice of the Availability of Language Assistance Services *(cont'd.)*

A copy of Blue Shield's *Notice of Availability of Language Assistance* (that includes both DMHC- and CDI-approved language) is available on Provider Connection at blueshieldca.com/provider under *Guidelines & resources, Patient care resources*, and then *Language Assistance Program.*

The notice states the following in English and in Blue Shield's threshold languages and non-threshold languages:

> "No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or
> 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357."

Enrollees requiring help to read a Blue Shield-generated non-standard vital document are instructed to call the toll-free telephone number on the back of their member ID card for at no cost interpretation or translation into the plan's threshold languages. When translation of the non-standard vital document is requested, Blue Shield provides the translation within twenty-one (21) calendar days of the request.

An approved notice of language assistance must accompany the provider's non-standard vital documents if those documents are related to IPA/medical group-generated claims/UM non-standard vital documents.

Request for Translation

Providers are not delegated to provide translations of non-standard vital documents and must forward such requests received from enrollees to Blue Shield.

A provider who receives a request for a vital document translation should call our Provider Customer Service at (800) 541-6652. Non-urgent requests should be forwarded to Blue Shield within one day if it is urgent or within two days if it is not urgent.

To forward the vital document to Blue Shield:

1. Complete Blue Shield's "Language Assistance Form" available at www.blueshieldca.com/en/provider/guidelines-resources/patient-care-resources/language-assistance;
2. Attach a copy of the document to be translated;
3. Fax the request to (248) 733-6331.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Timeliness Standards for Standard and Non-Standard Vital Documents

The following timeliness standards apply to Blue Shield-generated non-standard and standard vital documents or IPA/MG-generated claims/UM non-standard vital documents:

Element	Type of Request	Timeliness Standards
Provider receives a request for translation of an IPA/MG-generated claim/UM non-standardized vital document from a Blue Shield enrollee	Urgent: Response within one business day Non-Urgent: Response within two business days	Urgent: 1. Forward the following to Blue Shield within one business day: a) Request for translation b) Copy of the document 2. Log the following: a) Date request was received from enrollee b) Date request and document were forwarded to Blue Shield Non-Urgent: 1. Forward the following to Blue Shield within two business days: a) Request for translation b) Copy of the document 2. Log the following: a) Date request was received from enrollee b) Date request and document were forwarded to Blue Shield
Blue Shield requests an IPA/MG-generated claim/UM non-standardized vital document	Urgent: Within one business day Non-Urgent: Within two business days	Urgent: 1. Forward the following to Blue Shield within one business day: a) Copy of the requested document 2. Log the following: a) Date request was received from Blue Shield b) Date document was forwarded to Blue Shield Non-Urgent: 1. Forward the following to Blue Shield within two business days: a) Copy of the requested document 2. Log the following: a) Date request was received from Blue Shield b) Date document was forwarded to Blue Shield
Blue Shield enrollee requests a translation of a Blue Shield standard vital document from provider	All: Within one business day	All: 1. Provider informs the member to call the Blue Shield Member/Customer Service number on the back of his/her Member ID card or (866) 346-7198.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Cultural Awareness, Sensitivity (Diversity, Equity, and Inclusion), and Linguistic Resources and Training

Blue Shield is dedicated to reducing healthcare disparities among cultural and linguistic minority groups that exist within our communities. To increase knowledge and awareness of cultural and linguistically appropriate services (CLAS) we are sharing a free e-learning that offers Continuing Education Units (CEU) credits for physicians, physician assistants, nurse practitioners, and any other direct service providers interested in learning about CLAS. Additionally, we offer several websites that will provide guidance, tools, and information that may help provider offices treat diverse populations and assist you in compliance with LAP requirements. The topics covered by these websites include bias, cultural competency, diversity, effective communication, equity, inclusion, providing language services, and more.

Beginning January 2025, all contracted providers will be required to complete training on advancing health equity and will cover a variety of topics, including implicit bias, culturally and linguistically appropriate practices, diversity, equity, and inclusion, gender-affirming care, and more. This training will meet mandated requirements and will be reviewed annually to determine if there are any updated mandates. Once the training is finalized, a link to access the training will be provided to you.

Providers are expected to ensure that all contracted or employed providers and their staff who are in contact with LEP members receive education and training regarding Blue Shield's LAP through formal or informal processes.

Below you will find a list of helpful trainings and resources.

- We encourage you to attend "A Physician's Practical Guide to Culturally Competent Care." This training covers the fundamentals of CLAS, communication, and language assistance, including how to work effectively with an interpreter, and much more. This training along with additional free provider trainings and webinars are available on the U.S. Department of Health & Human Services Think Cultural Health website at https://thinkculturalhealth.hhs.gov/education/physicians
- Blue Shield Provider Connection Learning resources offer free provider training and webinars at www.blueshieldca.com/en/provider/news-education/learning-resources.
- American Academy of Family Physicians Health Equity Continuing Medical Education www.aafp.org/cme/topic/health-equity.html
- American Medical Association: Delivering Care, Health Equity www.ama-assn.org/delivering-care/health-equity
- Health Industry Collaboration Effort (HICE) Cultural and Linguistics Provider Toolkit www.iceforhealth.org/library.asp?sf=&scid=1284#scid1284

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Cultural Awareness, Sensitivity (Diversity, Equity, and Inclusion), and Linguistic Resources and Training *(cont'd.)*

- The Georgetown University Center for Child and Human Development – National Center for Cultural Competence Curricula Enhancement Module Series https://nccc.georgetown.edu/curricula/overview/index.html
- U.S. Department of Health and Human Services, Office of Minority Health. www.minorityhealth.hhs.gov

Multilingual Resources

- The Blue Shield website is offered in multiple language formats. Members can click the global icon located on the top left corner of our homepage to select their desired threshold language. In addition, several translated vital documents, including grievance forms, a confidential communications request, member forms, and notice of language availability are available online. www.blueshieldca.com/en/home
- Our downloadable Grievance Form includes an attached notice of the availability of language assistances services translated into 17 languages. www.blueshieldca.com/en/home/help-and-support/grievance-process
- Members can request confidential information using multilingual request forms on our confidential Communications Request page at www.blueshieldca.com/en/home/help-and-resources/confidential-communications-request
- Our Language Assistances sign may be viewed and downloaded or printed from our website by visiting www.blueshieldca.com/content/dam/bsca/en/shared/documents/legacy/Interpretive-Svcs-Poster.pdf
- Member Forms, including notice of availability of language assistance services are available at www.blueshieldca.com/en/home/forms-unauth

Monitoring Compliance

Blue Shield's LAP annual compliance audit includes:

1. Monitoring internal Blue Shield organizations, contractors, contracted health care providers, and network compliance with regulatory standards for the LAP, including the availability, quality, and utilization of language assistance services.
2. Tracking grievances and complaints related to its LAP.
3. Documenting actions taken to correct problems.

Use of Non-Preferred/Non-Participating Providers

Blue Shield requires facilities to notify members, in a manner that allows the member the opportunity to act upon such notification, when the proposed treatment includes either: (1) the use of a non-network provider or facility (e.g., non-network facility-based physician or non-network physician group providing services at the facility); or (2) the referral of a member to a non-network provider or facility for proposed non-emergent covered services.

Facility Directory

Blue Shield maintains a directory of Blue Shield Providers that is made available to members

In preparation for inclusion in Blue Shield's Directory publications the facility is required to attest to the accuracy of their data every 90 days in compliance with the 2020 Consolidated Appropriations Act (CAA) All providers with a contracted relationship with Blue Shield will display in the Blue Shield *Find a Doctor* online directory.

Facilities have an opportunity to leverage Provider Connection online tools to support the process of attestation and submitting provider directory information updates. Non-responsive providers will be suppressed from the directory until they have attested to their information.

There are two ways to update provider directory data:

1. Make changes directly on Provider Connection in the *Provider & Practitioner Profiles* section.
2. Log onto Provider Connection and download the Provider Data Validation Spreadsheet then upload the revisions back to Provider Connection.

Instructions for this update process and information on how to attest to data accuracy can be found in the following link www.blueshieldca.com/bsca/bsc/public/common/PortalComponents/provider/StreamDocumentServlet?fileName=PRV_CAA-provider-directory-instructions.pdf.

If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to Blue Shield for additional assistance in finding a provider. Providers, enrollees, potential enrollees, and the public can report inaccurate, incomplete, or misleading information with Blue Shield's Provider Directory by calling (800) 258-3089, by emailing providerdirectoryinaccuracies@blueshieldca.com, by filling out the "Report outdated information form" located on each provider results page on *Find a Doctor,* or by notifying the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI).

Facility Directory *(cont'd.)*

To discuss the information shared about your organization in the Blue Shield *Find a Doctor* online directory, please contact the Provider Information and Enrollment team at (800) 258-3091, from 6 a.m. to 6:30 p.m., Monday through Friday.

In order to reduce administrative burden on providers, Blue Shield may delegate some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the facility may work with the vendor in lieu of Blue Shield to complete directory maintenance tasks.

Health Information Data and Record Sharing with Blue Shield

Providers shall comply with State requirements regarding electronic health record data exchange, including without limitation those outlined in the California Health and Human Services Data Exchange Framework, and the compliance milestones established for Calendar Year 2022-2024 and other program policy and procedure requirements, and additional state and federal regulations as applicable, and as updated and amended from time to time. Such program requirements and State law, implementing regulations and regulatory guidance shall govern the sharing of electronic health record data beginning January 31, 2024. Blue Shield is able to receive electronic health record data through the following platforms: (i) EPIC Payer platform, (ii) Manifest MedEx platform, and (iii) State Qualifying Health Data Exchange platform. Providers shall participate in and utilize one of the aforementioned options in providing electronic health record data to Blue Shield within the timelines set forth in the State requirements as they may be amended from time to time. For informational purposes, as of January 1, the required timelines include:

On or before January 31, 2024, unless otherwise stated:

- General acute care hospitals, as defined by Section 1250. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Provider and physician organizations and medical groups. as defined by Section 127500.2. (Fewer than 25 physicians, and nonprofit clinics with fewer than 10 providers, the compliance date is 1/31/26.)
- Skilled nursing facilities, as defined by Section 1250, that currently maintain electronic records. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Clinical laboratories, as that term is used in Section 1265 of the Business and Professions Code, and that are regulated by the State Department of Public Health.
- Acute psychiatric hospitals, as defined by Section 1250. (Fewer than 100 beds and state-run acute psychiatric hospitals, the compliance date is 1/31/26.)
- Emergency medical services, as defined by Section 1797.72.

This page intentionally left blank.

Section 3: Medical Care Solutions

This page intentionally left blank.

Table of Contents

This page intentionally left blank.

Medical Care Solutions Program Overview

The Medical Care Solutions Program within Blue Shield's Health Solutions division is established to provide oversight of the delivery of care to members. Medical Care Solutions provide inpatient utilization management 7 days a week from 8 a.m. to 5 p.m., except for company designated holidays. The Blue Shield Medical Care Solutions professional staff includes California-licensed clinicians who monitor healthcare services delivered by contracted-physicians and providers for timeliness, appropriateness, and quality of care.

The Blue Shield Medical Care Solutions program consists of active ongoing coordination and evaluation of requested or provided health services to promote delivery of medically necessary, appropriate health care or services and quality, cost-effective clinical outcomes. The Medical Care Solutions Program is designed to assist Blue Shield contracted physicians, providers, and hospitals in ensuring the coverage of medically necessary services.

Blue Shield has developed Medical Care Solutions processes that address inpatient and outpatient utilization, as well as monitor quality of care, and care management. Medical Care Solutions processes include, but are not limited to, the following functions:

- Prior authorization/elective admission authorization
- Prior authorization of services
- Emergency services review
- Transplant management
- Utilization management (UM)/concurrent and retrospective review (post-service review)
- Medical Care Solutions for continuity and coordination of care
- Focused ambulatory care review
- Identification and referral of potential quality-of-care issues
- Clinical claims review
- Facility claims review
- Provider compliance review
- Review of high dollar cases
- Care Management

Medical Care Solutions Program Overview *(cont'd.)*

Blue Shield Medical Care Solutions will follow regulatory and accreditation Timeliness Standards for all urgent and non-urgent requests for services. Blue Shield will also send written notification to the member and providers to confirm the request determination. Blue Shield licensed case managers engage with members to ensure care needs are coordinated prior to and after a hospital confinement.

Members may self-refer or be referred to Medical Care Solutions Care Management through a variety of sources, including their physician, Social Services, family members, employers, etc.

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 *(cont'd.)*

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 and/or evidenced based clinical guidelines;
- 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.

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.

Utilization Management Criteria and Guidelines

The goal of the Blue Shield Medical Care Solutions Program is to promote the efficient and appropriate utilization of medical services and to monitor the quality of care given to members. To accomplish this goal, the program requires systematic monitoring and evaluation of the medical necessity and level of care of the services requested and provided. Blue Shield determines medical necessity and the appropriateness of the level of care through the prospective review of care requested and the concurrent and retrospective review of care provided. These reviews are conducted by Blue Shield clinicians, medical directors, pharmacists, peer review committees, physician peer reviewers and other consultants.

Blue Shield may also delegate utilization management (UM) activities to subcontracted entities. Blue Shield approval of the delegated entity's UM program is based on a review of its policies and procedures, demonstration of compliance with stated policies and procedures, and the ability to provide services to our members in keeping with various accreditation and regulatory requirements. All delegated activities are monitored and evaluated by the Blue Shield Health Solutions teams and the appropriate oversight committee to assist the delegated entity in improving its processes. Blue Shield retains the authority and responsibility for the final determination in UM medical necessity decisions and ensures appeals related to utilization issues are handled in a timely and efficient manner.

Medical necessity reviews (for both authorizations and non-authorizations) made by Blue Shield use a hierarchy of criteria for both medical and Mental Health/Substance Use Disorder (MH/SUD). 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:

- 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; *and*
- 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.

Utilization Management Criteria and Guidelines *(cont'd.)*

The criteria utilizes generally accepted standards of medical practice in the United States; and clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease, or its symptoms; and not part of or associated with scholastic education or vocational training of the patient; and 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, the outpatient department of a hospital, or in another facility at a lower level of care without adversely affecting the patient's condition or the quality of medical care rendered. The following are services that will not be covered at the inpatient level of care:

- For diagnostic studies that can be provided on an outpatient basis;
- For medical observation level of care;
- For personal comfort;
- In a pain management center to treat or cure chronic pain; or
- For inpatient rehabilitation that can be provided on an outpatient basis.

Utilization Management Criteria and Guidelines *(cont'd.)*

Blue Shield applies evidence-based clinical criteria and Medical Policy to determine medical necessity. Blue Shield and Blue Shield Life use the UM criteria found in the following resources to determine medical appropriateness and coverage. The resources are not listed in use order for utilization management and medically necessary decisions. The specific hierarchy for each line of business is determined by regulatory government bodies. For example, Medicare requires use of the Medicare Managed Care Manual and NCD/LCD's first.

- Center for Medicare & Medicaid Services (CMS) and other state and federal guidelines
    - *Note*: The Medicare Coverage Issues Manual for Durable Medical Equipment applies across product lines and can be found online at www.cms.gov all other services apply to Medicare
- Medicare Local (LCD) and National (NCD) coverage determination
- Medicare Managed Care Manual
- Guide to Clinical Preventive Services: Report to U.S. Preventative Services Taskforce
- Blue Shield Medication policies
- Standardized criteria sets (i.e., MCG®, DSM-5)
- Provider Organization Criteria or Guidelines
- Resources may include MCG®, Medicare Benefit Policy Manual Coverage Guidelines
- World Professional Association for Transgender Health (WPATH)
- American Society of Addiction Medicine (ASAM)
- Early Childhood Services Intensity Instrument (ECSII)
- The Child & Adolescent Level of Care Utilization System (CALOCUS-CASII)
- Level of Care Utilization System (LOCUS)
- Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder; Council on Autism Providers (CASP)
- Psychological and Neuropsychological Testing Billing and Coding Guide; American Psychological Association
- Clinical Guidelines for the Management of Adults with Major Depressive Disorder, Section 4. Neurostimulation Treatments; Canadian Network for Mood and Anxiety Treatments (CANMAT)
- Blue Cross® and Blue Shield® Service Benefit Plan Brochure (FEP PPO Plan only)
- Federal Administrative Manual (FEP PPO only)
- Federal Employee Program Medical Policy (FEP PPO only)

Utilization Management Criteria and Guidelines *(cont'd.)*

- AIM Specialty Health Radiology Guidelines (DSNP only)
- National Comprehensive Cancer Network Guidelines (DSNP only)
- DHCS Medi-Cal UM Criteria (DSNP only)

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 www.blueshieldca.com/provider and may be updated quarterly as needed. For fully-insured products, Mental Health and Substance Use Disorder medical necessity review is conducted by Blue Shield's MHSA and utilizes 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, Early Childhood Service Intensity Instrument (ECSII) guidelines, Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder, Psychological and Neuropsychological Testing Billing and Coding Guide, and Clinical Guidelines for the Management of Adults with Major Depressive Disorder. Additional guidelines may be added as they become available from non-profit professional associations in accordance with California law. Medical services for the treatment of gender affirming care, eating disorder or substance use disorder are reviewed by Blue Shield utilizing the criteria as outlined in the UM Program Description.

Medical Necessity Denials

The Blue Shield Chief Health Officer has overall responsibility for Blue Shield's Medical Care Solutions Program. The Blue Shield Senior Medical Director in Medical Care Solutions along with other Blue Shield Medical Directors are responsible for the implementation and providing clinical expertise of the Medical Care Solutions program. A licensed physician reviews all medical necessity denials; licensed pharmacists review medical necessity for pharmaceuticals/drugs and place of administration covered in the medical benefit. Board-certified physicians from the appropriate specialty assist in making medical necessity determinations, as needed.

When a hospital admission, continued stay, pharmaceutical/drug, or proposed service is determined to be not medically necessary or not covered under the member's plan, a peer-to-peer request is made to discuss the plan of care with the attending clinician. A determination is made within 72 hours of the request and the facility / attending physician is notified by phone or fax within 24 hours of the decision. Written notification of the denial is also sent to the member or responsible party, the attending physician, and the hospital. Notification for routine pre-service requests is within two business days of making the decision. For urgent requests, notification is within 72 hours of receipt of requests.

Medical Necessity Denials *(cont'd.)*

Per your Blue Shield contract, if authorization for services in an outpatient or inpatient hospital facility or an extension of days is required and not obtained or is denied by Blue Shield, neither Blue Shield nor the member is financially responsible for the denied days. The member may be held financially responsible only if the hospital obtains in writing an acknowledgment of financial liability from the member or responsible party prior to rendering the service. This acknowledgment must be specific to the admission or days denied by Blue Shield.

Blue Shield Medicare Advantage plan members are held financially responsible for any denied services received, only in accordance with federal Centers for Medicare & Medicaid Services (CMS) regulations. Prior to the member's time of discharge, if the member disagrees with the decision to discharge or the hospital is not discharging the member, but the Health Plan or delegated IPA/medical group will no longer continue coverage of the inpatient hospital stay, the member must receive the CMS-required "Notice of Discharge Medicare Appeal Rights" (NODMAR) no later than the day before hospital coverage ends. A member is entitled to coverage until at least noon of the day after such notice is provided. The member or member representative must sign the letter, or the hospital must document that the member refused to sign the letter. Copies of the letter must be maintained in the member's medical record for auditing purposes.

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), the Blue Cross Blue Shield Association Medical Policy Panel (BCBSA MPP), and the California Technology Assessment Forum (CTAF).

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.

Medical policy information is accessible through Provider Connection at www.blueshieldca.com/en/provider/authorizations/policy-medical/list.

Medication Policy

The Blue Shield Pharmacy and Therapeutics (P&T) Committee reviews pharmaceuticals. The P&T Committee bases clinical decisions on the strength of the available scientific evidence, consensus guidelines, and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other relevant information as deemed appropriate including the clinical trial data submitted to the FDA to support a new drug, abbreviated new drug, or biologic license application (NDA, ANDA, BLA).

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

Medication Policy *(cont'd.)*

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 formulary placement and medication coverage policy recommendations are based on the principles of evidence-based medicine, which is a review of scientific evidence from peer-reviewed published medical literature.
    a. Multi-center, randomized, prospective clinical trial results published in the peer-reviewed literature demonstrating the treatment to be at least as safe and effective as other established modalities of therapy are considered as best evidence.
    b. In addition to randomized controlled trials, medical society guidelines, and accepted community standard of practice will be considered.

Only pharmaceuticals that have been FDA-approved will be considered eligible for coverage, based on medical necessity.

Note: Benefit and eligibility criteria supersede medical necessity determinations.

Additional authorization for select medical drugs may also be required for the administration of the drug at an outpatient hospital facility site, in addition to authorization of coverage for the drug which may require step therapy. Refer to the Medication Policy. For Blue Shield Medicare Advantage HMO Members, Blue Shield follows Medicare guidelines for risk allocation, 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.

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.

Medication policy information is available on Provider Connection at www.blueshieldca.com/en/provider/authorizations/policy-medications or by contacting Provider Information & Enrollment at (800) 258-3091.

For information concerning the Blue Shield member grievance process, please refer to Section 1 of this manual.

Admission Authorization

Prior Authorization/Elective

The physician or hospital must obtain authorization (when applicable; Refer to www.blueshieldca.com/provider and click on *Authorizations*) for Blue Shield member hospital admissions from the designated Medical Care Solutions team five days prior to an elective admission. If prior authorization is not required, the physician or hospital must notify the Medical Care Solutions team at time of admission. Providers can now submit authorization requests online. Requests can be submitted for authorization directly to Blue Shield for any of the following services: inpatient hospital, outpatient services, home health care/home infusion services, residential, and DME/orthotics services. Simply go to Provider Connection at blueshieldca.com/provider and click on *Authorizations*. Enter necessary information and you will receive a response back in your message center advising of the status of your authorization request. Authorizations can be submitted electronically to Blue Shield. For specific guidelines, refer to Blue Shield's 837 Companion Guide found on Provider Connection.

Additional information such as operative reports or progress reports that support the authorization can be faxed to Blue Shield. Please include a coversheet containing all the necessary information included.

Hospitals can also call the number on the member's identification for prior authorization. Generally, for PPO products, the request for admission authorization is referred to Blue Shield or a third-party review organization. For Access+ HMO and Blue Shield Medicare Advantage (HMO), Blue Shield generally delegates the responsibility for administering the UM program to a contracted IPA/medical group; however, both the IPA/medical group and Blue Shield's Medical Care Solutions department are to be notified of the hospital admission. The designated primary care physician is responsible for coordinating the member's care and ensuring that appropriate authorizations are provided. For the Access+ Point of Service (POS) product, the UM responsibility may be contingent upon the type of benefit the member is seeking (i.e., HMO or opt-out). For example, if a POS member chooses the opt-out feature, the primary care physician is not involved, and Blue Shield Medical Care Solutions will review the authorization request.

In any event, including the absence of the member's card, the Blue Shield eligibility telephone lines will direct callers to the designated Medical Care Solutions team (i.e., the IPA/medical group or Blue Shield) and the appropriate telephone number to call for authorization.

Blue Shield members are also advised in their Summary of Benefits and *Evidence of Coverage* (EOC) that they are responsible for obtaining or assuring that their physicians (attending or specialist) obtain prior authorization from the designated Medical Care Solutions team for specified services.

Admission Authorization *(cont'd.)*

Prior Authorization/Elective *(cont'd.)*

Note: If hospital fails to obtain authorization prior to providing covered services to a member, as required, or if hospital provides services outside of the scope of the authorization obtained, then Blue Shield, or its delegate shall have no obligation to compensate hospital for such services; hospital will be deemed to have waived payment for such services and shall not seek payment from Blue Shield, its delegate, or the member.

Ambulatory Surgeries/Procedures

Facility-based ambulatory surgeries/procedures are performed in an acute care facility on an outpatient basis or in an ambulatory surgery center. Surgical diagnostic procedures are identified as facility-based ambulatory surgeries/procedures. Unless Blue Shield and the IPA/medical group have contracted differently, Blue Shield authorization is required for facility-based ambulatory surgeries/procedures.

Office-based ambulatory surgeries/procedures (minor procedures) should be performed in a physician office setting. If it is medically necessary that they be performed in a facility setting, on an outpatient or inpatient basis, notification to Blue Shield Medical Care Solutions is required. If an IPA or medical group schedules an office-based surgery/procedure in an outpatient facility setting, the hospital should confirm that the IPA provided notification to Blue Shield Medical Care Solutions.

With the exception of fully capitated IPA/medical groups, all other IPA/medical groups must notify Blue Shield of any authorized ambulatory surgeries via submission of an authorization log.

A list of frequently performed office-based ambulatory surgeries/procedures (minor procedures) can be found in the Appendix 4-E of this manual or obtained electronically from your Blue Shield Network Manager.

Admission Authorization *(cont'd.)*

Emergency Services

Prior authorization is not required for urgent and emergency services. If these services result in a hospital inpatient admission, the attending physician or the hospital must notify the designated Medical Care Solutions team within 24 hours of that admission. Medical Care Solutions notifies the members identified PCP of admission within 24 hours. The member should notify his or her primary care physician (HMO) as soon as it is medically possible for the member to provide notice.

> *Note*: Failure to comply may result in non-coverage for the services and/or greater out-of-pocket expense for PPO members.

Notification of hospital admission is required within 24 hours. The designated Medical Care Solutions team reviews the request for admission within one day from the receipt of request and notifies the facility of the determination by phone, fax and/or in writing of the decision. Admissions are reviewed for medical necessity, level of care, appropriateness of care, and benefit determination. The hospital, member, and attending physician are also notified in writing of the determination, including the initial authorized length of stay or denial of the authorization request.

Discharge Date Notification

For all inpatient stays, the hospital/facility must notify Blue Shield's Medical Care Solutions department via fax at (844) 295-4639 of a patient's discharge date and disposition within 24 hours of the member's discharge.

Discharge Planning

The Blue Shield Medical Care Solutions team is committed to ensuring our members receive services at the appropriate level of care. Our concurrent review team will collaborate with facilities to coordinate discharges to the next level of care. This collaboration will begin upon admission, with the concurrent review team engaging facility staff to understand the member's needs upon discharge.

The Blue Shield Medical Care Solutions will reach out to the facility to plan authorizations for next level of care, placement to available in-network providers, and/or any durable medical equipment necessary. For complex cases, our internal teams in utilization management and case management will collaborate by phone or, if needed, interdisciplinary meetings with facility resources and plan staff in attendance.

Admission Authorization *(cont'd.)*

Outpatient Authorizations

TYPE OF SERVICE / PROCEDURE	ALL LINES OF BUSINESS
Ambulance Service Non-Emergency: Blue Shield covers non-emergency ambulance services using our contracted providers. Non-emergency ambulance requires prior authorization. Non-emergency ambulance (surface and air) services may include transferring a member from a non-contracted facility to a contracted facility, or between contracted facilities, in connection with an authorized confinement/admission, and under other circumstances as necessary, if medical treatment or observation is required. *Note:* Non-Emergency services provided solely for the convenience of the patient or physician would not be covered.	For PPO, Direct Contract HMO, or HMO members: Go to Provider Connection at www.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.
FDA-Approved Prescription Pharmaceuticals/Drugs FDA-approved prescription pharmaceuticals/drugs provided as part of a medical service and administered in the physician office, outpatient facility, ambulatory infusion center, or through home health/home infusion. (Does not apply to drugs or products that are excluded from the member's benefit.)	A complete list of medications and their authorization requirements for coverage in the medical benefit can be found on Provider Connection at www.blueshieldca.com/provider under *Authorizations*, *Clinical policies & guidelines,* then *Medication policy.* Faxed requests must be submitted on the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form Providers may also submit prior authorization requests online by going to www.blueshieldca.com/provider under *Authorizations* then *Request a medical authorization.* An additional link to the *Medication Policies User Guide* is available on the *Medication Policy* homepage. Contact Blue Shield Medical Care Solutions (800) 541-6652 or Fax: (844) 262-5611 or Submit online, with attached documentation, via AuthAccel in the *Authorizations* section of Provider Connection at www.blueshieldca.com/provider.

TYPE OF SERVICE / PROCEDURE	ALL LINES OF BUSINESS
Mental Health and Substance Use Disorder For commercial plans managed by Blue Shield's mental health service administrator (MHSA). This includes fully-insured HMO, PPO, and EPO plans. Prior authorization is required for: • Non-emergency mental health or substance use disorder Hospital admissions, including acute and residential care • Outpatient Mental Health and Substance Use Disorder Services listed below, as required by the applicable plan's Evidence of Coverage or Health Service Agreement: o Behavioral Health Treatment (BHT) including Applied Behavior Analysis (ABA). o Electro-convulsive Therapy (ECT). o Transcranial Magnetic Stimulation (TMS). o Intensive Outpatient Program. o Partial Hospitalization Program. o 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). For Blue Shield Medicare Advantage Plans Prior authorization is required for: • Non-emergency mental health or substance use disorder Hospital admissions • Other Outpatient o Electroconvulsive Therapy (ECT). o Transcranial Magnetic Stimulation (TMS). o Neuropsychological Testing • Inpatient admissions • Partial hospitalization programs • Intensive outpatient programs • Office Based Opioid Treatment (OTP)	Fully-Insured Products and Self-Funded BHT/ABA requests Contact MHSA (800) 378-1109 Self-Funded/Shared Advantage Products Contact Blue Shield Medical Care Solutions (800) 541-6652 Group Medicare Contact MHSA (800) 985-2398 Individual Medicare Advantage Prescription Drug (IMAPD) Contact Blue Shield Medical Care Solutions (800) 541-6652 or Fax: (844) 807-8997 or online by going to www.blueshieldca.com/provider under *Authorizations, Authorization tools,* then *Request a medical authorization.*

TYPE OF SERVICE / PROCEDURE	ALL LINES OF BUSINESS
Radiology /Radiotherapy Radiology services for a given geographic area may be directed to specific providers. The process may differ depending upon the network structure in an individual geographic area or for procedures managed by NIA. For PPO and Direct Contract HMO members, no prior authorization is required, except for procedures managed by NIA. The following radiologic procedures are managed by National Imaging Associates, Inc. (NIA): • CT, All Examinations • MRI/MRA, All Examinations • Nuclear Cardiology Imaging • PET (Positron Emission Tomography) **Select radiology services provided to members in HMO and Blue Shield Medicare Advantage plans continue to be reviewed by Blue Shield Medical Care Solutions. Prior authorization may be required.**	Submit authorization requests online at www.RadMD.com or contact NIA at (888) 642-2583

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 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 transplant referrals must be to an approved network transplant facility for benefits to be paid. Contact the Blue Shield Transplant Team at (916) 841-1130 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 to the Medical Care Solutions Transplant Department in Rancho Cordova.

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 members requires authorization by Blue Shield for members in a PPO product, and by the IPA/medical group for members in an HMO product.

> *Note:* Charges incurred as a result of cadaver organ donor evaluation, donor maintenance, or 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 and PPO – For HMO members, both the transplant evaluation and 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. For PPO members, with the exception of IFP PPO, the evaluation requires notification only. All Blue Shield members are entitled to transplant evaluations at any Blue Shield transplant network facility approved for the specified organ or transplant type, whether or not that facility has a contractual relationship with the IPA/medical group.

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

Transplant Authorization

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

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

- Bone marrow
- Stem cell
- 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)

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

No special centers are required as long as a Blue Shield of California contracted facility is used, and, for kidney transplants, the facility is Medicare-certified.

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

Transplant Authorization *(cont'd.)*

Requests for transplants must include the following:

- Subscriber ID, requesting MD, 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 the information to (916) 350-8865, Attn: Transplant Team

Admission and Concurrent Inpatient Review

Blue Shield applies industry standard evidenced-based protocols and guidelines in the admission and concurrent review process. Blue Shield Medical Care Solutions reviewers may conduct concurrent review throughout an admission to determine level of care and continued medical necessity. The reviews may be conducted telephonically, electronically (electronic medical record access), reviewing faxed clinical records and/or with onsite reviews on an as needed basis.

> *Note:* Authorization is not needed for a maternity admission for a routine delivery. If the baby stays after the mother is discharged, then the physician must contact Blue Shield for pre-certification of additional days for the baby.

Licensed clinicians evaluate for medical necessity and appropriateness of the level of care, including sub-acute care, and may require supporting medical documentation from the hospital including remote access to the hospital's electronic medical record. Hospitals must contact Blue Shield within 24 hours of admission. Authorization for additional days beyond the authorized length of stay must be obtained from the designated Medical Care Solutions team one day prior to the end of the authorized length of stay. Failure to request additional days prior to rending services may result in non-coverage. The facility is notified within 72 hours of the request by telephone, fax, or in writing of the determination to continue the stay. If the provider is notified of the determination by phone, written notification will follow within 24 hours of the determination.

Admission and Concurrent Inpatient Review *(cont'd.)*

If the designated medical director or physician reviewer determines that the services are not medically necessary or at the appropriate level of care, he/she will contact the attending physician for a peer to peer discussion to develop a mutually agreed upon discharge plan.

A hospital employee, such as a Discharge Planner or Hospitalist, may request a referral for a member into one of Blue Shield's care management programs by contacting the Medical Care Solutions Reviewer.

To complete the authorization process and enable timely claims payment, the patient's discharge date and disposition must be communicated to Blue Shield Medical Care Solutions within 24 hours of discharge.

Subacute Level of Care Criteria

Blue Shield will determine which subacute levels of care are applicable to the subacute services provided based on the following criteria:

Level I:

(i) 24-Hour skilled nursing care observation and management;

(ii) Routine oral, intra-muscular injection and subcutaneous drug administration;

(iii) Intravenous administration (single);

(iv) Insulin dependent (SQ Insulin);

(v) Nasogastric tube, gastric tube, jejunostomy tube, or jejuno-gastric tube (enteral feeding services and supplies included);

(vi) Colostomy/ileostomy care;

(vii) Foley catheter care (with daily irrigations);

(viii) Traction and Positioning;

(ix) Up to two (2) hours of therapy per day, up to five (5) days per week of rehabilitation services for any combination of the following (evaluation included) by a licensed practitioner:

  (A) Physical therapy.

  (B) Occupational therapy, which includes Self Care, Dressing, Bathing, Toileting (B&B).

  (C) Speech therapy, which includes swallowing/eating, Cognitive rehabilitation.

  (D) Respiratory therapy.

(ix) Wound care (Stage I, II) decubitus post-surgical wound/dressing care.

Subacute Level of Care Criteria *(cont'd.)*

Level II:

All therapies as noted in Level I, plus the following additional care or conditions:

(i) Intravenous administration and therapy (two or more medications); Central Lines, Total Parenteral Nutrition (TPN);

(ii) Isolation;

(iii) Tracheostomy care, Respiratory Care requiring frequent suctioning;

(iv) Wound Care Stage 3 possible;

(v) Two (2) to three (3) hours of therapy per day, up to five (5) days per week of rehabilitation services for any combination of the following (evaluation included) by a licensed practitioner:

  (A) Physical therapy.

  (B) Occupational therapy, which includes Self Care, Dressing, Bathing, Toileting (B&B).

  (C) Speech therapy, which includes swallowing/eating, Cognitive rehabilitation.

  (D) Respiratory therapy.

Level III:

All therapies as noted in Levels I and II, plus the following additional care or conditions:

(i) Major wound care (Stage III or IV) Negative Pressure wound therapy pump (wound vac);

(ii) Permanent tracheostomies (includes supplies);

(iii) Chest tube(s);

(iv) Shunt management;

(v) Tracheostomy decanulation;

(vi) Tracheostomy requiring enteral feeding;

(vii) Peritoneal dialysis;

(viii) Special beds (i.e., Hill-Rom, KCI);

(ix) High-Cost medications IV/IM/SQ; IV TPN/Lipids.

Level IV:

All therapies as noted in Levels I, II and III, plus the following additional care or conditions:

(i) Ventilator management; and/or

(ii) Mutually agreed upon diagnoses requiring extensive skilled nursing care; 24-hour care.

Continuity of Care for Members by Non-Contracted Providers

Continuity of Care Services are those covered services that a qualifying member is entitled to receive pursuant to California Health and Safety Code Section 1373.96, Completion of Covered Services, and Public Health Service Act, Title XXVII, part D, Sections 2799A-3 and 2799B–8, Continuity of Care (hereinafter Consolidated Appropriations Act, 2021 (CAA), Section 113).

Newly covered members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracted provider who was providing services to the member at the time the member's coverage became effective under their Blue Shield plan.

Existing Blue Shield members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracted provider who was providing services to the member at the time the provider's agreement with Blue Shield terminated. Following termination, providers agree to continue rendering provider services that are Continuity of Care Services to members who qualify for completion of Continuity of Care Services as determined by Blue Shield at the rates and under terms set forth in the provider's agreement. For members who retain eligibility under the plan contract through which they are enrolled and who are receiving covered services from a provider at the time of termination, the provider shall continue to provide covered services until such covered services are completed or until Blue Shield makes reasonable and medically appropriate provision for the assumption of such Covered Services by another provider. The provider shall be compensated for such covered services in accordance with the provider's agreement with Blue Shield. Blue Shield shall make reasonable efforts to timely notify such members that a provider is no longer a contracting provider and, for members in HMO plans, shall make reasonable and timely efforts to effectuate the assumption of covered services by another provider.

A member can request continuity of care services by completing Blue Shield's Request for Continuity of Care Services form, available by calling Blue Shield Member Services or downloading from blueshieldca.com, then either mailing or faxing the completed form for review to the address or fax number listed on the form at least thirty (30) days before the health plan takes effect or as soon as the member becomes aware of the need for continuity of care services.

Section 4: Billing and Payment

This page intentionally left blank.

Table of Contents

Table of Contents *(cont'd.)*

Section 4: Billing and Payment

This section outlines Blue Shield's billing procedures and requirements for submitting claims. It also describes Blue Shield claims payment policies for specific situations, such as coordination of benefits (COB), and explains Blue Shield's process for resolving billing issues.

Claims Submission

> *Note:* Hospitals billing on behalf of physicians should submit claims for physician services using a CMS 1500 electronic format, not on the UB-04 (or successor) form. These services are not contracted under the hospital agreement and, therefore, will be rejected if submitted for payment on the UB-04 (or successor) form.

Real Time Claims Settlement

Real-Time Claims Settlement provides an enhanced provider experience through speed, accuracy and most importantly transparency in the claim's adjudication process. The end goal solution Blue Shield is building toward is an end-to-end automated process from claim creation to payment reconciliation.

Current Enhancements

While we are working to fully automate the transaction process, one of our first steps is the creation of a Real Time Claims Web Tool in Provider Connection. This tool will allow you to estimate and submit claims online to process with a target of 3-9 seconds. While it does take some data entry, it can provide a glimpse of how we are working to speed up the claims adjudication process.

The Web Tool provides two main features:

1. Claim Estimate: Providers will have the ability to submit a claim estimate and receive a response with payment assurance for the total payment (including payer payment and member liability amounts) for services. A claim estimate can be submitted up to 7 days prior to services performed and will be valid up to 7 days.
2. Claim Submission: Providers will have the ability to submit claims to Blue Shield of California and connect with Blue Shield's processing system for real time adjudication. The finalized claim/payment decision is then presented to the provider. Claims are then paid upon the regular payment cadence.

The Real Time Claims Web Tool is available to registered users on Provider Connection at www.blueshieldca.com/provider. If you are not a registered user, please see the section *Welcome to Provider Connection* on the home page of www.blueshieldca.com/provider for instructions on how to register.

Claims Submission *(cont'd.)*

Real Time Claims Settlement *(cont'd.)*

Current Enhancements *(cont'd.)*

Once you are registered on Provider Connection you will need to request access to the Real Time Claims Web Tool via your Account Manager, MSO, or Billing Service. After access is obtained for the Real Time Claims Web Tool it can be opened by clicking *Claims* on the menu bar then clicking *Real Time Claims*.

The Real Time Claims Web Tool is an intuitive system designed with provider ease of use in mind. A resource guide can be found on the Real Time Claims landing page under *Guidelines and resources.* In addition, a reference guide, FAQ documentation, and an eLearning can be found on the Real Time Claims landing page under *News and* Education.

Future State

To further realize our long-term solution, Blue Shield is working to make claims processing automated. These offerings revolutionize how we as an industry process claims and we look forward to continuing to deliver new capabilities in the future. The upcoming claims processing solutions are further defined below.

Blue Shield is working to create a platform for a direct system-to-system connection between providers and Blue Shield. This solution will make it possible for claims to be automatically generated and is intended to help reduce administrative burden on providers. This will be accomplished through a connection with the provider's Electronic Health Records (EHR) system and Revenue Cycle Management (RCM) system to create and send a claim to Blue Shield through a digital connection to be adjudicated in real-time.

Claims Submission *(cont'd.)*

Completing the UB-04 Form

Electronic Submissions

Hospitals and facilities are asked to submit claims electronically that do not have a medical record attached and receive remittance electronically or via web/automated solution for faster and more efficient claims processing. Electronically submitted claims will be acknowledged within 2 days. Refer to the HIPAA ANSI Implementation Guides, the National Uniform Billing Committee (NUBC) UB-04 Data Element Specifications, and the Blue Shield 837 Transaction Companion Guide for detailed instructions on electronically submitted claims. For specific guidelines, refer to Blue Shield's 837 Companion Guide found on Provider Connection at www.blueshieldca.com/provider.

For information on electronic submissions, go to Provider Connection or call the Electronic Data Interchange (EDI) Help Desk at (800) 480-1221. Hospitals and facilities may submit claims online through an approved clearinghouse. To learn more, go to Provider Connection at www.blueshieldca.com/provider, click on *Claims, Manage Electronic Transactions,* and *how to enroll in EDI.*

To ensure efficient processing, Blue Shield **may** require additional information for the following types of claims. We require all claims to be submitted through your electronic connection and only submit on paper with additional documentation if the claim suspends processing or is denied for additional information.

- Exception Claims,* including, but not limited to:
  - Stop-Loss
  - Implants
  - Trauma
  - Transplants
- Medicare supplement claims
- Other Organ transplant claims
- Claims for inpatient admissions with covered and non-covered days during the same stay
- Late discharge (Documentation of medical necessity must be attached to the claim form.)

* This list of claims is not all-inclusive. For all exceptions, please refer to your hospital contract.

Claims Submission *(cont'd.)*

Completing the UB-04 Form *(cont'd.)*

Providers should transmit their National Provider Identifier (NPI) in the billing provider segment of each claim along with their tax ID. Blue Shield will reject claims that do not contain this information. For specific information on where to input the NPI in the electronic format, providers may call the EDI Help Desk at (800) 480-1221 or visit Provider Connection at www.blueshieldca.com/provider.

Paper Submission

For faster processing and turnaround, please submit all claims electronically. When paper claims forms must be used, Blue Shield requires accurately completed UB-04 (or successor) forms to process claims quickly and efficiently. Paper claims will be acknowledged within 15 days. To facilitate the efficient and accurate claims processing of paper forms, original red claim forms are required. Also, ensure:

- Data entered onto the claim form is done in Arial font, point size 10–12
- Only black ink is used
- Data is entered in CAPITAL letters
- Dot matrix printers are not used. Laser printers are recommended.
- No italics, red ink, stickers, or rubber stamps are used
- No handwritten descriptions are placed on the claim
- No narrative descriptions of procedure, modifier or diagnosis are on the claim. The CPT, Modifier, ICD-10-CM, or ICD-10-PCS codes are sufficient. For drug codes, the CPT, NDC, Modifiers JW (indicator single dose container drug waste) and JZ (indicator no single dose container drug waste) are required.
- No white correction fluid is used
- Data is not touching box edges
- No special characters are used (e.g., dollar signs, punctuation marks, parentheses)
- NPI is required for providers submitted on paper claims.

Please refer to Appendix 4-F UB-04 General Instructions for billing instructions. Providers may also refer to the *California UB-04 Billing Procedures Manual*, available from the California Healthcare Association, for detailed instructions on the UB-04 Form.

Claims Submission *(cont'd.)*

Other Required Billing Information

Outpatient Charges – Submit outpatient claims electronically or on the UB-04 (or successor) claim form if medical records are attached. Except as otherwise specified in your agreement with Blue Shield, claims not submitted in accordance with these requirements will be rejected. Use appropriate Revenue, CPT/HCPCS Codes and modifiers for the following outpatient services:

- Surgical Services
- Emergency Services and Urgent Care Services
- Dialysis Services
- Infusion Therapy Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy
- Radiology/Pathology/Diagnostic Tests
- Clinical Laboratory Services
- Pharmaceutical Services
- All Other Outpatient Services

Enter the codes in Form Locator 44. Be sure to include all applicable Revenue, CPT/HCPCS Codes and modifiers. Refer to Appendix 4-A: Reimbursement for Outpatient Services, for reimbursement details around each outpatient service. In accordance with national billing guidelines, Blue Shield requires the use of detailed, specific codes instead of generic, general codes.

Professional Charges – Facilities that act as the billing agent for hospital-based physicians (i.e., emergency room physicians, clinic physicians, anesthesiologists, radiologists, pathologists, etc.) and other allied health professionals must obtain a separate nine-digit Blue Shield professional provider identification number (PIN) for both group and individual providers to bill for these services. Services billed using Revenue Code 096X – 098X, CPT Codes with Modifier 26, and professional-only CPT Codes, will be denied if billed on the UB-04 (or successor) claim form.

Claims Submission *(cont'd.)*

Other Required Billing Information *(cont'd.)*

Global CPT Codes – As noted above, Blue Shield does not pay for professional charges; accordingly, a global CPT Code should not be used when a technical component-only CPT Code is available. In the event a global CPT Code is billed, and a technical component-only CPT Code is available, the global CPT Code will be recoded to the technical component-only CPT Code and reimbursement will be determined based on the technical component-only CPT Code.

Facility Fees for Professional Office Visit Services – Blue Shield does not reimburse or pay facilities for clinic facility charges billed under Revenue Codes 510-529. Reimbursement for facility fees associated with office services is included in the physician professional fee and is not paid separately to facilities.

Skilled Nursing Facility Charges – Hospital and free-standing skilled nursing facility services must be billed on the UB-04 (or successor) claim form with the appropriate Revenue Code and CPT/HCPCS Codes to indicate the level of care or identified excluded service.

Dialysis Charges – Free-standing dialysis center services must be billed electronically or on the UB-04 (or successor) claim form if medical records are attached with the appropriate Revenue Code, CPT/HCPCS Codes and modifiers, in order to receive payment for services rendered. Except as otherwise specified in your agreement with Blue Shield, claims not submitted in accordance with these requirements will be rejected.

Facilities must submit claims electronically for professional charges or on a CMS 1500 claim form if medical records are attached and must include not only the billing agent NPI, but also the NPI of the provider who performed the service. Except as otherwise specified in your agreement with Blue Shield, claims not submitted in accordance with these requirements will be rejected. Block 24J of the CMS 1500 Form or the rendering provider field of the electronic record format is the appropriate location for showing the rendering provider NPI. Please note that for Blue Shield Medicare Advantage claims, the rendering physician's state license or UPIN must be entered in this field.

Claims Submission *(cont'd.)*

Reference Materials

In addition to the *California UB-04 Billing Procedures Manual* and the NEIC or NUBC Specification Manual, other reference materials are available to ensure appropriate coding. Various types of codes used in submitting claims are listed below.

Revenue Codes – Codes that identify a specific accommodation or ancillary service and used to determine payment. For appropriate coding and specific information about revenue codes, please refer to the *California UB-04 Billing Procedures Manual.*

> *Note:* Certain billing scenarios may require Blue Shield to apply billed charges to Revenue Code 249. In some billing scenarios, Blue Shield may add Revenue Code 249 to identify combined or non-payable charges.

ICD-10-CM (Clinical Modification) – The ICD-10-CM List contains categories, subcategories, and codes. Characters for categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.

ICD-10-PCS (Procedure Coding System) – ICD-10-PCS codes are composed of seven characters. Each character is an axis of classification that specifies information about the procedure performed. Within a defined code range, a character specifies the same type of information in that axis of classification (e.g., the fifth axis of classification specifies the approach in sections 0 through 4 and 7 through 9 of the system).

Claims Submission *(cont'd.)*

Reference Materials *(cont'd.)*

CPT (Current Procedural Terminology) Codes – Five-digit codes for identifying medical services and procedures performed by physicians. The American Medical Association publishes the *CPT Code Manual*. Use this document when billing for the following types of services:

- Surgical Services
- Emergency Services and Urgent Care Services
- Dialysis Services
- Infusion Therapy
- Immunizations
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy
- Radiology/Pathology/Diagnostic Tests
- Clinical Laboratory Services
- All Other Services

HCPCS Level II – Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician office. Appropriate HCPCS Codes should be used to bill outpatient pharmaceuticals including units of service based upon the HCPCS Code description.

NDC (National Drug Code) – 10- or 11-digit universal drug product identifier found in the *Red Book*, the *Blue Book,* or the *National Drug Code Directory.* When billing for drugs, supplies, and equipment, use HCPCS and NDC codes. NDC Codes are required for new drugs without an assigned HCPCS Code, for these services facilities must bill using the appropriate Revenue Code, unclassified J-Code (HCPCS) and the NDC Code with description in order to receive payment.

The billing document should include the following information:

- Name of patient
- Date of service
- Drug name
- Drug strength
- NDC Number and quantity

Claims Submission *(cont'd.)*

Reference Materials *(cont'd.)*

Please refer to the HIPAA ANSI Implementation Guide and Blue Shield of California 837 Transaction Companion Guide for submitting claims electronically.

AWP – AWP refers to the Average Wholesale Price of pharmaceuticals dispensed per NDC Code as set forth in a nationally-recognized pricing source such as First Data Bank and its supplements or other such sources, as determined by Blue Shield.

ASP – ASP refers to the Average Sales Price is a market based price that reflects the weighted average of all manufacturer sales prices that includes all manner of discounts. The ASP is issued by CMS quarterly based on the information submitted by the manufacturer and is a reference point to estimate acquisition costs.

Medicare Crossover

Claims for Blue Shield Medicare Supplement plans are automatically sent to Blue Shield by the Medicare carrier. Providers do not need to submit these claims to Blue Shield for supplemental coverage processing.

Please check your Medicare Remittances for notification that your original claim has been crossed over to ensure that you do not send any duplicate claim to Blue Shield of California. If it has crossed over and you have not received a remit within 30 days, please check claim status with the appropriate Blue plan and then re-submit electronically with the local Blue plan if necessary.

When Blue Shield is the patient's secondary carrier, submit claims electronically using the process below or contact your clearinghouse or billing system vendors for EDI Medicare secondary submission. If EDI secondary is not available, attach a copy of Medicare's RA to the back of the UB-04 (or successor) or CMS 1500 form even if the remittance advice indicates a complete denial of payment by Medicare.

Claims for Blue Shield Medicare Supplement plans are automatically sent to Blue Shield by the Medicare carrier. Providers do not need to submit these claims to Blue Shield for supplemental coverage processing.

Please check your Medicare Remittances for notification that your original claim has been crossed over to ensure that you do not send any duplicate claim to Blue Shield of California. If it has crossed over and you have not received a remit within 30 days, please check claim status with the appropriate Blue plan and then re-submit electronically with the local Blue plan if necessary.

Claims Submission *(cont'd.)*

Medicare Crossover *(cont'd.)*

When Blue Shield is the patient's secondary carrier, submit claims electronically using the process below or contact your clearinghouse or billing system vendors for EDI Medicare secondary submission. If EDI secondary is not available, attach a copy of Medicare's RA to the back of the UB-04 (or successor) or CMS 1500 form even if the remittance advice indicates a complete denial of payment by Medicare.

Instructions for COB Electronic Submission

837 Professional COB Claims – Secondary/Tertiary Electronic Claims to Blue Shield

- Claim level information can be submitted; Blue Shield requires line level on professional claims
- Standard list refers to HIPAA compliant codes established by CMS and other government entities
- Both 2430 segments must equal original total charge in CLM02 in order to balance

Claim Information (2300)

CLM*TERT837PDLLRSNDTST*1000***23>>1*Y*A*Y*Y*B~

837 Institutional COB Claims – Secondary/Tertiary Electronic Claims to Blue Shield

- Claim level information needs to be submitted; Blue Shield may also receive line level on COB institutional claims.
- Standard list refers to HIPAA compliant codes established by CMS and other government entities.
- Both 2430 segments must equal original total chard in CLM02 in order to balance.

Claim information (2300)

CLM*COBSECTERTST*11751.32***11A>1*Y**Y*Y*********Y~

Claims Submission *(cont'd.)*

Medicare Crossover *(cont'd.)*

Instructions for COB Electronic Submission *(cont'd.)*

CAS Claim Level Adjustments: (Select one of the following): (Loop 2320)

- CO Contractual Obligations
- CR Correction and Reversals
- OA Other Adjustments
- PI Payor Initiated Reductions
- PR Patient Responsibility

CAS02 Claim Adjustment Reason Code: (Use appropriate adjustment reason codes)

Examples:

1 = Deductible Amount

2 = Coinsurance Amount

3= Copayment Amount

Examples

CAS*PR*1*9*7.93~

CAS*OA*93*15.06~

> *Note:* Claim Adjustment Reason Codes are available via Washington Publishing at www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/.

Contact the EDI Help Desk at (800) 480-1221 with any questions about Medicare supplemental claims that should have been forwarded but were not. Questions about the amount paid on the supplemental claim should be directed to the appropriate Blue Shield Customer Service department.

Claim Attachments

Coordination of Benefits (COB) Documentation

When Blue Shield is the patient's secondary carrier, submit claims electronically using your vendors EDI secondary process. For more information, see Blue Shield instructions for secondary COB electronic submission in the Medicare Crossover section or contact the EDI Help Desk at (800) 480-1221.

If EDI secondary is not available, attach proof of the primary carrier's payment or denial and a copy of the other carrier's identification card (see Coordination of Benefits information further in this section).

Detail of Charges

Occasionally, Blue Shield may contact providers for an itemization of charges (e.g., exception claims). In those instances, prompt cooperation will expedite the payment process.

Emergency Room Visits

A copy of the emergency room report is required to be submitted upon Blue Shield's request.

Hospital-Acquired Conditions / Never Events Documents

A copy of the medical record and an itemization of charges must be submitted with acute care hospital claims for inpatient admissions during which there was a Hospital-Acquired Condition (HAC) or Never Event (see Hospital-Acquired Conditions / Never Events information in this section).

Medicare Secondary

Please check your Medicare Remittances for notification that your original claim has been crossed over to ensure that you do not send any duplicate claim to Blue Shield. If it has crossed over and you have not received a remit within 30 days, please check claim status with the appropriate Blue plan and then resubmit electronically with the local Blue plan if necessary.

For more information, see Blue Shield instructions for secondary COB electronic submission in the Medicare Crossover section or contact the EDI Help Desk at (800) 480-1221.

If EDI Medicare secondary is not available, attach a copy of Medicare's RA to the back of the UB-04 (or successor) or CMS 1500 form even if the remittance advice indicates a complete denial of payment by Medicare (see the Medicare Non-Duplication of Coverage information in this section).

Claims Processing Logic and Payment Policies

The following provides a high-level, general overview of Blue Shield's payment processing logic. Please refer to Provider Connection at www.blueshieldca.com/provider under the *Claims* tab for the full payment policies. Please call Provider Information & Enrollment at (800) 258-3091 for additional information.

Blue Shield Claim Edits and Industry Standard Correct Coding

Blue Shield utilizes claims editing software that uses correct coding from industry standard sources, such as Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and health plan-developed policies, as applicable, during the claims adjudication process. Additional sources may be used as defined in the Claim Editing Payment Policy.

The claim editing software is also able to identify previously submitted historical claims that are related to current claim submissions, which may result in adjustments to claims previously processed.

Claims editing software will be updated periodically, without notification, to reflect the addition of newly released/revised/deleted codes and their associated claim edits, including but not limited to NCCI revisions, and health plan payment policies.

Prescreen Claims

Blue Shield provides web access to Clear Claim Connection, a tool that enables providers to prospectively prescreen claims. Access and training instructions for Clear Claim Connection can be found on Provider Connection at www.blueshieldca.com/provider under *Claims*, then *How to submit claims.*

Payment Policies

Blue Shield has adopted payment policies for licensed facility provider types. Blue Shield Payment Policies are updated periodically to reflect the addition of newly released/revised/deleted codes without notification and can be found on Provider Connection at www.blueshieldca.com/provider under the *Claims* tab.

Out of Sequence (Split Claims)

Denial of payment for "out of sequence" claims arises when two or more procedures with the same date of service that would have resulted in a denial of one of the procedures (e.g., mutually-exclusive procedures; component procedures to others) are submitted by the provider out of sequence on different dates.

Claims Processing Logic and Payment Policies *(cont'd.)*

Readmission Review Policy

The Readmission Review Policy applies to Commercial and Medicare Advantage network acute care facilities that are reimbursed for inpatient services by diagnoses-related group (DRG) or case rate methodologies.

Blue Shield will not allow separate reimbursement for claims that have been identified as a readmission. A readmission is a subsequent acute inpatient admission to the same facility or another facility that (i) operates under the same Blue Shield facility agreement, (ii) has the same tax identification number as facility, or (iii) is under common ownership as facility, and

1) Occurs up to 30 days from discharge, and

2) Has the same or similar diagnoses as the initial admission.

Blue Shield will utilize clinical coding criteria or licensed clinical medical reviewer to determine if the subsequent admission is for:

- The same or closely-related condition or procedure as the prior discharge.
- An infection or other complication of care.
- A condition or procedure indicative of a failed surgical intervention.
- An acute decompensation of a coexisting chronic disease.
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow up period.
- An issue caused by a premature discharge from the original admission facility.

Once the initial review has identified a readmission, Blue Shield will utilize clinical coding criteria and a licensed medical professional to review the medical records related to the initial admission to determine if the readmission is a preventable readmission. The medical record review of the initial admission will focus on the following:

1. Whether discharge plans were followed according to generally accepted medical standards. These are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered.

Claims Processing Logic and Payment Policies *(cont'd.)*

Readmission Review Policy *(cont'd.)*

2. Whether written discharge instructions were provided and explained to the member/caregiver prior to discharge.
3. Whether documentation supports that durable medical equipment has been arranged for the member and the member has been appropriately educated on its use.
4. Whether documentation in the hospital record indicates that an appointment was made within the first week or within an appropriate time frame after discharge from the initial admission.
5. Whether documentation indicates that all required prescriptions were given to the member and the member was educated in the appropriate use of the medication.
6. Whether appropriate telephone numbers have been given to the member for calls to the hospital or primary care provider for related discharge questions.
7. Whether documentation supports that all salient financial and social needs of the member have been addressed.
8. Whether a health care advocate/provider did an in-home safety assessment and appropriate follow up as needed.
9. Whether the member left the hospital against medical advice and readmitted within 30 days. If so, the member's readmission is not preventable.

Blue Shield will review claims subject to this policy using the following methods: Pre-adjudication Review and/or Post payment/Adjustment Review.

Exclusions

The following admission diagnoses and circumstances are excluded from this Readmission Review Policy:

- Behavioral Health / Substance Use Disorder
- Cancer-related or Encounter for Chemotherapy
- Pregnancy / Abortion / Labor / Delivery
- Admissions for covered transplant services during the global case rate period for the transplant
- Planned readmission
- Discharge status 7 (expired), 20 (patient left against medical advice), or 30 (interim claim)

Claims Processing Logic and Payment Policies *(cont'd.)*

Readmission Review Policy *(cont'd.)*

Readmission Review Documentation

Providers should document the reason the member was admitted and daily progress notes on the member. The Case Manager must document all care plan associated with post-acute care transition.

Facilities must submit the following information to Blue Shield for readmission review:

- All clinical notes/charts related to initial admission and readmission(s).
- All Hospital Case Management and care transition notes/documentation related to the initial admission.

Special Billing Situations

Billing of Exchange-Purchased Plans

Under California and federal law, subscribers receiving subsidies for Exchange-purchased individual plans that are delinquent in premium payments have a three-month grace period to pay all outstanding premiums due. During the first month of this grace period, Blue Shield will continue to process all appropriate claims for services rendered to the subscriber and any dependents. During the 2nd and 3rd months of the grace period, coverage for the subscriber and dependents is suspended until all outstanding premiums are paid to Blue Shield. When premiums become delinquent and the member is in the 2nd or 3rd month of the grace period, Blue Shield will provide written notification to providers advising them that the member's eligibility has been suspended. In the event that premiums are not received by the end of the subscriber's three-month grace period, claims will be denied.

Coordination of Benefits (COB)

Coordination of Benefit (COB) claims should be received electronically up to Tertiary. Blue Shield follows CMS guidelines. For facility inpatient claims, the COB is submitted at the claim level. For facility outpatient and professional claims, the COB is typically provided at claim line level. Please see instructions for COB electronic submission on pages 10-11 of this document or refer to Blue Shield's 837 Companion Guide found on Provider Connection at www.blueshieldca.com/provider.

Special Billing Situations *(cont'd.)*

Electronic Data Interchange Transaction Set Implementation Guide Drug Requirements

837 Institutional Claims

Home infusion services and drug claims must be billed on the 837 institutional electronic claims transaction using the following guidelines:

- Report name of the drug in the claim note (Loop 2300 NTE02). Use "MED" in NTE01.
- Report description using up to 80 bytes, placed in order of the service lines (See example below).
- Report HCPCS code of drug at the service line (Loop 2400 SV202-2). Use "HC" in SV202-1.
- Report date of service in the service line (Loop 2400 DTP03). Use "472" in DTP01.
- Use qualifier "N4" for NDC format 5-4-2 (Loop 2410 LIN02).
- Report the national drug code (Loop 2410 LIN03).
- Refer to the 5010 837 Institutional Guide, pages 43-44, for more information.

Notes:

207 2300 NTE01 Note reference - "MED" is Medications.

207 2300 NTE02 Description - Name of drugs. Use up to 80 bytes and show in order of service lines.

Example:

(NTE*MED*J9265 PACLITAXEL 30MG J1644 HEPARIN 1000UN J3490 CIMETIDINE 300MG~).

A new field is available in 5010 for description of services that can be used for drug specifics or any additional information needed for the claim. The NTE segment can also still be utilized.

Examples:

Professional Claim / SV102-7

SV1*HC>J3490>>>>>MULTITRACE-4 10ml Conc.*11.94*UN*1.000***1~

Institutional Claim/ SV202-7

SV2*0821*HC>90999>G4>V6>>>NON-SPECIFIC PROCEDURE CODE*2785*UN*1~

Special Billing Situations *(cont'd.)*

End Stage Renal Dialysis (ESRD) Hospital (Medicare)

ESRD claims are paid based on the End Stage Renal Dialysis Prospective Payment System (ESRD PPS).

ESRD PPS payment is based on the following factors; through date, date of birth, condition code 73 or 74, value code A8 and A9/value code amounts, revenue code, patient's height, and patient weight to be able to determine the correct payment. Refer to the *Medicare Claims Processing Manual Chapter 8 – Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims.*

Genetic and Molecular Testing

A procedure description is required for Unlisted Genetic and Molecular Testing procedure codes with use of the Genetic Testing Unit (GTU). The specific GTU for each procedure code can be identified by accessing Concert Genetics Provider Portal at www.concertgenetics.com/join-blue-shield-california. Providers are required to bill according to the CPT coding established in the Concert Genetics portal.

Claim Type	Field or Segment	GTU Format
837I Transaction [Institutional Claims]	Loop 2400 segment SV202-7	Insert the exact GTU or the GTU preceded by "GTU-." For example, insert either: • 6V98G • GTU-6V98G
UB-04 Form [Institutional Claims]	Form Locator 80	

Home Health (Medicare)

For faster processing and turnaround, please submit all claims electronically. Services requiring medical records must be billed on the CMS 1500 / UB-04 (or successor) claim form.

Providers accepting Medicare rates are paid at the Home Health Prospective Payment System (HHPPS).

The following items must be included in order to determine the correct Medicare payment:

- The Episode Timing
- Severity Points
- HIPPS Codes billed with Revenue Code 0023 with zero billed amounts on the line

Refer to the *Medicare Claims Processing Manual Chapter 10 – Home Health Agency Billing*.

Special Billing Situations *(cont'd.)*

Hospice Billing (Commercial)

Hospice is a type of care that focuses on the palliative care of a terminally ill patient's pain and symptoms. Terminal illness is defined as a medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course.

Authorization

All hospice services require prior authorization.

- HMO Plans – Authorization through the delegated IPA or medical group.
    - Direct Contracting IPA– Authorization through Blue Shield's Medical Care Solutions Department.
- PPO Plans – Authorization through Blue Shield's Medical Care Solutions Department.

Billing of Covered Services

For faster processing and turnaround, please submit all claims electronically. Services requiring medical records must be billed on the CMS 1500 / UB04 (or successor) claim form with the appropriate Revenue Code, Type of Bill, CPT/HCPCS Codes and modifiers in order to receive payment for services rendered.

When billing for hospice care, claims should have Type of Bill (TOB) 81x or 82x and the following revenue codes:

- 651 – Routine home care
- 652 – Continuous home care
- 655 – Inpatient respite care
- 656 – General inpatient care
- 657 – Physician care

For hospice arranged services, the provider of service will bill the hospice, and the hospice will reimburse the provider. The hospice will then include those services in the billing to Blue Shield. Blue Shield will reimburse the hospice for all covered services based on the contracted rates.

Special Billing Situations *(cont'd.)*

Hospice Billing (Commercial) *(cont'd.)*

Consultation Visit Prior to Hospice Care

The hospice will bill a consultation visit prior to hospice care services using HCPCS G0337 – Hospice Evaluation and Counseling Services, Pre-election.

Please call Provider Services & Enrollment at (800) 258-3091 for additional information or for answers to questions not addressed above.

Hospice Billing (Medicare)

CMS issued Program Memorandum Intermediaries/Carriers – AB-02-015 (2/7/02) CMS Pub. 60AB *Clarification of Payment Responsibilities of Fee-for-Service Contractors as it Relates to Hospice Members Enrolled in Managed Care Organizations (MCOs) and Claims Processing Instructions for Processing Rejected Claims* to clarify regulations regarding payment responsibility for hospice patients enrolled in managed care plans, as well as provide specific claims processing requirements to ensure payment for such claims. The information below is reprinted from that program memorandum:

Covered Services

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a provider treating an illness not related to the terminal condition or an MA to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;
2. Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;
3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or
4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. HMO monthly capitation payments will begin on the first day of the month after the beneficiary has revoked his or her hospice election.

Special Billing Situations *(cont'd.)*

Hospice Billing (Medicare) *(cont'd.)*

Billing of Covered Services

Medicare hospices will bill the RHHI for Medicare beneficiaries who have coverage through managed care just as they do for beneficiaries with fee-for-service coverage, beginning with a notice of election for an initial hospice benefit period, and followed by claims with types of bills 81x and 82x. If the beneficiary later revokes election of the hospice benefit, a final claim indicating revocation, through use of Occurrence Code 42, should be submitted as soon as possible so that the beneficiary's medical care and payment are not disrupted. Occurrence Code 42 cannot be used in situations where the beneficiary is transferred from one hospice provider to another. The HMO may directly bill Medicare carriers for attending physician services, as listed above, in keeping with existing processes.

Medicare physicians may also bill such service directly to carriers if all current requirements for billing for hospice beneficiaries are met. Revised requirements for such billing were recently set forth in Transmittal 1728, Change Request 1910 of the *Medicare Carriers Manual* (MCM), Part 3, effective April 2002 and specifies use of Modifiers GW and GV. When these modifiers are used, carriers are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File (CWF) in Medicare claims processing systems.

For medical services, for a condition not related to the terminal condition for which the beneficiary elected hospice, a claim must be submitted to the intermediary using the condition code 07. If physician services are billed to carriers, the instructions in Transmittal 1728, Change Request 1910 of the MCM should be followed and should specify the use of Modifier GW.

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries. Managed care enrollees who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice is revoked.

Special Billing Situations *(cont'd.)*

Hospice Billing (Medicare) *(cont'd.)*

Timely Filing

These instructions apply to all contractors for claims filed in the timely filing period for managed care enrollees who have elected hospice. The timely filing period extends from the date of service to the end of the calendar year after the year service was rendered. However, if a service was provided in the fourth quarter of a calendar year, the claim will be timely to the end of the second year after the year in which the service was rendered. Since there have been allegations of lack of compliance with the regulatory requirements for Medicare fee-for-service contractors to process hospice claims for managed care beneficiaries, exceptions to timely filing will be considered on a case-by-case basis. Exceptions to the timely filing requirements will be determined by Medicare contractors on a case-by-case basis in accordance with applicable CMS guidelines.

Physician Billing Instructions For Non-Hospice Services

CMS has specific coverage rules that apply when an individual is covered under a Medicare hospice program. Treatment for the specific hospice related condition is covered under the scope of the hospice benefit. Treatment for non-hospice related services must be specifically billed to denote the following:

1. Services are not related to the specific terminal illness covered through hospice. For example, the hospice related illness is congestive heart failure.
2. A separate medical condition not related to treatment for hospice is eligible for payment under Medicare Part B, provided the billing is done properly (the specific codes designated by Medicare (i.e., GW modifiers) are utilized when billing). A separate medical condition not related to treatment for congestive heart failure is eligible for payment under Medicare Part B, provided the medical documentation regarding the separate medical condition is included.
3. Separate, non-hospice related treatment for things such as renal failure or related red blood cell production issues that meet Medicare criteria for Procrit injections would be distinct from the CHF condition being treated under the hospice program. As such they are eligible for coverage under Medicare Part B.
4. The billing should be done with a GW modifier and should denote that the treatment is not for the CHF condition, which is coded as covered under hospice.

Resources: Medicare Hospice Manual; discussion with the Hospice staff confirming that the Renal Failure and Red Blood cell production issues are not part of the scope of the hospice treatment for CHF; Frank Abrahamian at US Government Services; and conversations with CMS staff and NHIC staff; DHHS Program Memorandum.

Special Billing Situations *(cont'd.)*

Interim Billings

Interim bills for services subject to reimbursement at either a Case Rate or Per Diem Rate will be paid at the applicable Case Rate and/or Level of Care Per Diem Rate as they are received. When the final bill (type of bill 114) is received it will be paid at per diem with an EOB message that reads: "We have made a courtesy payment on this claim. Please resubmit the claim if it is determined to be a Stop Loss payment situation after the patient is discharged."

Once Blue Shield receives the resubmitted claim, complete with admit to discharge itemization, we will verify Stop Loss contract language, review previous payments, and adjudicate the claim accordingly. Additional information may be requested before final Stop Loss payment can be determined.

Intermediate Inpatient Accommodation Services

Intermediate Inpatient Accommodation Services are considered to be Medical/Surgical Level of Care accommodation services, unless otherwise noted in the provider contract or as determined by Utilization Review.

Newborn Screening Program
Department of Health Services (DHS) Genetic Disease Branch (GDB)

DHS's Genetic Disease Branch that administers the state's mandatory Newborn Screening Program, advised newborn screening providers that they will not bill patients or health plans for these services. These services must be billed by the facility collecting the specimen. Blue Shield's payments for these services are included in the hospital's capitated or per diem rates.

Observation Services

Blue Shield reimburses observation services pursuant to the contract, which may differ from the payment methodology used by other payors, including Medicare. These services may be included in the global case reimbursement or included in the inpatient reimbursement if the member is subsequently admitted.

Special Billing Situations *(cont'd.)*

Pre-Admission Testing

Pre-admission testing includes any service related to a patient's planned inpatient admission on the date of admission and the three (3) calendar days preceding the date of admission, this includes the 72-hour time period immediately preceding the time of admission when the outpatient principal diagnosis is similar to, or same as, the inpatient or same day surgery diagnosis.

Diagnostic services, defined below, are considered part of pre-admission testing:

Code	Description
0254	Drugs incident to other diagnostic services
0255	Drugs incident to radiology
030X	Laboratory
031X	Laboratory pathological
032X	Radiology diagnostic
0341	Nuclear medicine, diagnostic
0343	Diagnostic Radiopharmaceuticals
035X	CT scan
0371	Anesthesia incident to Radiology
0372	Anesthesia incident to other diagnostic services
040X	Other imaging services
046X	Pulmonary function
0471	Audiology diagnostic
048X	Cardiology
053X	Osteopathic services
061X	MRI
062X	Medical/surgical supplies, incident to radiology or other diagnostic services
073X	EKG/ECG
074X	EEG
0918	Testing - Behavioral Health
092X	Other diagnostic services

Non-diagnostic services are also considered part of pre-admission testing if they are furnished in connection with the principal diagnosis that necessitates the member's inpatient admission. Unless your agreement with Blue Shield specifies a different timeframe, pre-admission testing that occurs within 72 hours prior to the inpatient admission will be included in the DRG rate, per diem rate, case rate, or any other fixed Blue Shield rate for covered services and will not be paid separately. All claims billed separately for these services must be accompanied with the appropriate ICD-10 codes.

Special Billing Situations *(cont'd.)*

Pre-Operative Testing

Pre-operative testing is defined as tests performed prior to, and required for, the surgery generally including but not limited to all clinical laboratory services and diagnostic tests. The pre-operative testing period can cover any timeframe of one hour to one month before the actual surgery.

All pre-operative testing required for the surgery should be billed on the same claim as the applicable surgery in order to receive payment. All pre-operative tests performed are considered to be included in the surgical case rate.

Present on Admission (POA)

Specific details for billing the POA indicator are available on Provider Connection at www.blueshieldca.com/provider under the *Claims* tab.

HIPAA 5010 837 contains specific details of where the POA is located. Please refer to the HIPAA Implementation Guidelines or the FAQs for EDI, ERA & EFT located on Provider Connection at https://www.blueshieldca.com/provider/claims/electronic-transactions/faq.sp

Rehabilitation Therapy Inpatient (Medicare)

Inpatient rehabilitation therapy services are paid under Inpatient Rehabilitation Facility Prospective Payment System (IRFPPS).

Payments are based on the Case-Mix Group (CMG) supplied by the provider. Providers must supply the CMG Code billed with Revenue Code 0024 with zero billed amounts on the line.

Refer to the *Medicare Claims Processing Manual Chapter 3 – Inpatient Hospital Billing*.

Self-Referral

Billing for services that are considered "self-referred" should be billed as:

For Professional Claims

Loop 2310F NM103= SELFREFERRAL

Loop 2310F NM104= BLANK

First Name = SELFREFERRAL

Last Name = BLANK

Sample: NM1*DN*1*SELFREFERRAL*****XX*1002233777~

Special Billing Situations *(cont'd.)*

Self-Referral *(cont'd.)*

For Institutional EDI Claims

Loop 2310F NM103= SELFREFERRAL

Loop 2310F NM104= BLANK

First Name = SELFREFERRAL

Last Name = BLANK

Sample: NM1*DN*1*SELFREFERRAL****XX*1002233777~

Skilled Nursing (Medicare)

Skilled nursing inpatient services are paid under a Prospective Payment System (PPS). Providers who have language in their Agreement to pay at a percent of provider's billed charges in accordance to the Charge Master; the reimbursement rates set forth in the Agreement; and the reimbursement established by the Medicare program to pay at the lesser of contracted rates or at Medicare reimbursement, will be subject to claims being priced at the PPS fee schedules regulated by CMS.

Providers **must** supply the appropriate CMS Skilled Nursing Facility Health Insurance Prospective Payment System ("SNF HIPPS") code and zero charges. This information is required in order to price the claim at the Medicare rates. If the SNF HIPPS(s) code is not on the claim, the claim shall default to the lowest SNF HIPPS(s) level for the provider's locality for determining reimbursement in accordance with the provider's agreement with Blue Shield. Refer to the *Medicare Claims Processing Manual Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated Billing*.

Where to Submit Claims

Commercial Exception Claims

Hospitals with negotiated exception rates should submit paper claims (manufacturer invoice, when applicable) along with the UB-04 and itemization to the following address:

Blue Shield of California
Hospital Exception Unit
P.O. Box 629010
El Dorado Hills, CA 95762-9010

For BlueCard claims, hospitals with negotiated exception rates should submit paper claims (manufacturer invoice, when applicable) along with the UB-04 and itemization to the following address:

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630
(800) 622-0632

For more detailed information about the BlueCard Program claims process, refer to Appendix 5-A of this manual or access the BlueCard Program web page at www.blueshieldca.com/provider.

Electronic Claims

Claims are submitted in the ASC X12 837 5010 format. Blue Shield has contracted with several vendors for providers to submit claims at no cost.

To enroll in electronic claim submission, providers can use any approved clearinghouse listed on Provider Connection. Provider may submit claims at no charge using vendors Office Ally, TriZetto Provider Solutions or Ability Network. These vendors can be contacted at www.blueshieldca.com/provider in the *Claims* section under *How to submit claims* or by contacting the EDI Help Desk at (800) 480-1221.

The many benefits to the provider for using electronic submission include reporting/acknowledgment of receipts, faster payment, improved accuracy, no claim forms, no postage and handling, and the ability to submit to a single location.

The creation of the National Provider Identifier (NPI) was mandated by the Health Insurance Portability and Accountability Act (HIPAA). The NPI is an attempt to ensure that all medical providers can be identified by a single identifier across all payor systems. To implement the NPI, Blue Shield developed a plan to cross reference the NPI to the correct provider records in our system. Providers must apply for their type 1 and/or type 2 National Provider Identifier through the CMS NPPES website. The NPI needs to be registered with Blue Shield before submitting claims.

Where To Submit Claims *(cont'd.)*

Electronic Claims *(cont'd.)*

HIPAA 5010 went into effect January 1, 2012. This federal regulation requires the use of standard X12 transactions to report and inquire about healthcare services. For questions about 5010, please contact the EDI Help Desk at (800) 480-1221.

Paper Claims

For faster processing and turnaround, please submit all claims electronically. When medical records must be submitted, please use the post office box assigned by the member's plan type. Claims may also be sent to Blue Shield's central mail processing facility for appropriate distribution, although this process may cause some delay. Please refer to Appendix 4-C for a listing of these locations, as well as claims submission locations for specific programs/accounts.

Transplant Claims*

The Transplant All-Inclusive Global Case Rate Payment Period includes all inpatient and outpatient hospital, professional, ancillary services, and products received by the patient during the Global Case Period.

Itemized institutional and professional bills must be submitted on appropriate billing forms, e.g., UB-04 (or successor) forms for institutional services or CMS 1500 claim forms for professional services and attached to the Blue Shield Organ Transplant Package Billing Form (Included in the Exhibit C of the Transplant Amendment signed by the facility) unless otherwise stated in your contract.

Hospitals that are submitting Package Billings for transplant or transplant related services should send paper claims along with the Organ Transplant Package Billing Form to the following address:

Blue Shield of California
Hospital Exception and Transplant Unit
P.O. Box 629010
El Dorado Hills, CA 95762-9010

* This does not apply to kidney transplants unless the facility has an exception case rate specific to kidney transplants.

BlueCard® Program Claims

The BlueCard® Program is a national program that enables Blue Cross and Blue Shield (BCBS) Plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield Plan's service area. The program links participating healthcare providers with all independent Blue Cross and Blue Shield Plans across the country through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

The program allows hospitals and facilities to conveniently submit claims for patients from out-of-state Blue Plans, either domestic or international, to Blue Shield of California. Blue Shield is your primary contact for BlueCard claims processing, correspondence, and provider inquiries.

For faster processing and turnaround, please submit all claims electronically. All claim correspondence and paper claim forms that require medical records, can be mailed to BlueCard Program:

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630
(800) 622-0632

For more detailed information about the BlueCard Program claims process, refer to Appendix 5-A of this manual or access the BlueCard Program web page at www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/bluecard.

Facility Compliance Review (FCR)

In order to comply with our employer group and provider agreements and to ensure that appropriate billing practices are followed, Blue Shield has developed a comprehensive Facility Compliance Review (FCR) program that involves a comprehensive line-by-line bill audit. The program reviews inpatient and outpatient claims to validate their conformance with provisions of the facility's agreement.

Blue Shield audits claims for billing accuracy, allowable charges, medical necessity, Hospital Acquired Conditions and Never Events to ensure consistency with currently accepted standards in the industry. These standards include but are not limited to those defined by Optum reference manuals and followed by other commercial payors, as well as the UB-04 Billing Manual guidelines, the National Uniform Billing Committee guidelines and CMS guidelines. The program encompasses Blue Shield claims for all lines of business and all facilities.

Categories of charges that are subject to review and payment denial include but are not limited to those charges that are mutually agreed to in Blue Shield's hospital contracts; those charges that are determined to be not medically necessary; those for which there is no substantiating documentation; and those considered to be unbundling of another global charge, such as room and board charges or other facility room charges. Precedence for denial of such charges has been established by Optum resource manuals, and other commercial payors, as well as the Uniform Bill (UB04) Billing Manual guidelines and definitions.

To complete an audit as expeditiously as possible, Blue Shield may ask a hospital to submit medical records; Emergency Room Notes, Trauma Flowsheet, Physician Progress Notes, Physician Orders, History and Physical, Consultations, Discharge Summary, Operative Report and Implant Log. Blue Shield may request a copy of the UB-04 (or successor) and a detailed itemization if the claim has been electronically submitted. Timely submission of requests will expedite claims processing.

For questions regarding this program, please contact Provider Information & Enrollment at (800) 258-3091.

Disputes to the Facility Compliance Review results must be submitted in writing and include specific detailed supporting documentation to the following address:

Blue Shield of California Provider Dispute Resolution Office
Attention: Hospital Exception and Transplant Team
P.O. Box 629010
El Dorado Hills, CA 95762-9010

Incidental Procedures

Incidental procedures are outpatient services provided to members in conjunction with other outpatient covered services. Incidental procedure services and supplies are considered included in a global procedure charge(s).

A list of incidental procedures is provided in Appendix 4-D of this manual.

Hospital-Acquired Conditions / Never Events

Blue Shield believes that when a member enters a hospital for treatment of a medical problem, the member should not suffer or experience additional injuries, infections, or other serious conditions during the course of the member's stay. Accordingly, Blue Shield expects all Blue Shield participating hospitals to take proper precautions to prevent unnecessary and avoidable injuries or illnesses. As part of Blue Shield's commitment to improving the quality of care available to members, Blue Shield has adopted payment policies that encourage hospitals to reduce the incidence of certain hospital-acquired conditions (HACs) and "Never Events."

HACs are avoidable conditions that could reasonably have been prevented through application of evidence-based guidelines. Such conditions are not present when patients are admitted to a hospital but occur during the course of the stay.

Never Events are errors or events that should never happen in a hospital. The Centers for Medicare & Medicaid Services (CMS) defines Never Events as "serious and costly errors in the provision of health care services that should never happen."

Blue Shield will not pay or otherwise reimburse participating hospitals for inpatient services related to those HACs and Never Events listed on Provider Connection at www.blueshieldca.com/en/provider/auth/claims/policies-guidelines/payment-policies.

Hospital-Acquired Conditions / Never Events *(cont'd.)*

Specifically:

- Blue Shield will not reimburse hospitals for services provided during an inpatient admission that would not have been provided in the absence of a HAC, including a higher level of care or additional inpatient days. Following are various reimbursement methodologies and how the presence of a HAC may modify reimbursement:

    - **Per Diem Rate Reimbursement –** If the HAC does not impact the member's length of stay or the level of care provided to the member, no adjustment will be made to the per diem rate reimbursement otherwise payable to the hospital. If, as a consequence of the HAC, the member's length of stay is increased, Blue Shield will not reimburse the hospital for any additional inpatient days attributable to the HAC. If, as a consequence of the HAC, the member receives services at a level of care higher than that which the member would have received in the absence of the HAC, Blue Shield will reimburse the hospital at the per diem rate applicable to the level of care that would have been necessary had the HAC not occurred.
    - **Case Rate Reimbursement –** If the HAC does not impact the member's length of stay or the level of care provided to the member, no adjustment will be made to the case rate reimbursement otherwise payable to the hospital. If, as a consequence of the HAC, the member's length of stay exceeds the number of days covered by the applicable case rate, Blue Shield will reimburse the hospital at the applicable case rate only. If the HAC does not impact the member's length of stay, but, as a consequence of the HAC, the member receives services at a level of care higher than that which the member would have received in the absence of the HAC, Blue Shield will reimburse the hospital for any days exceeding the number of days covered by the applicable case rate at the per diem rate applicable to the level of care that would have been necessary had the HAC not occurred.
    - **Percent of Charge-Based Reimbursement –** Blue Shield will not pay or reimburse any charges for services related to the HAC. If, as a consequence of the HAC, the member receives services at a level of care higher than that which the member would have received in the absence of the HAC, Blue Shield will reimburse the hospital only for charges applicable to the level of care that would have been necessary had the HAC not occurred.
    - **DRG Reimbursement –** Blue Shield will not pay or reimburse the hospital for any services related to the HAC. Reimbursement will be calculated as though the secondary diagnosis was not present.

Hospital-Acquired Conditions / Never Events *(cont'd.)*

- **Stop Loss Reimbursement –** For purposes of calculating stop loss reimbursement, if any, payable to the hospital, Blue Shield will disallow all charges for services related to the HAC.

- Blue Shield will not reimburse hospitals for any services related to a Never Event.
- In no event, including, without limitation, nonpayment by Blue Shield, shall a participating hospital bill, charge or seek compensation or reimbursement from a member, or any individual responsible for such member's care, for hospital services related to a HAC or Never Event. Without limiting the foregoing, participating hospitals shall not seek payment from a member, or any individual responsible for such member's care, for Covered Services for which payment was denied by Blue Shield because such Covered Services were related to a HAC or Never Event.

The list of Hospital Acquired Conditions (HAC)/Never Events identifying codes are listed on Provider Connection at www.blueshieldca.com/en/provider/auth/claims/policies-guidelines/payment-policies.

Blue Shield Explanation of Payments (EOP)

Blue Shield pays participating hospitals directly for covered services provided to our members. Providers are required to receive claims payments electronically via Electronic Funds Transfer (EFT). Providers are required to receive Electronic Remittance Advice (ERA) showing how the claim was processed or view Explanation of Payment (EOP) using Provider Connection at www.blueshieldca.com/provider. An Explanation of Benefits (EOB) is also provided to members advising them of their financial responsibility, if any.

When a Blue Shield network hospital provides services, we base payment on allowed amounts according to negotiated per diems, case rates, or percentage discounts (unless the hospital is a capitated HMO facility). These negotiated rates are based on the contract in effect on the day the patient is admitted to the hospital. These amounts provide the basis of the patient's liability. The EOB message on the member's copy will vary slightly from what appears on the hospital's copy and will indicate Blue Shield's payment to the hospital.

Tools at Provider Connection at www.blueshieldca.com/provider allow registered billing providers to find claim and payment details and generate claims reports. Providers can download a copy of the printed EOP from Provider Connection. The information displayed on the claims details section of the website is the same information found on the provider's printed EOP.

Blue Shield Explanation of Payments (EOP) *(cont'd.)*

Electronic Remittance Advice (ERA)

Utilizing Electronic Remittance Advice (ERA) allows providers to reconcile their accounts receivable in a timely manner.

ERA data is used for automatic posting of claim payments. Auto-posting of payments requires assistance from your practice management system vendor.

ERA is an electronic version of an explanation of medical payment in HIPAA-compliant files. Providers are required to receive ERA files or view Explanation of Payment (EOP) using the Blue Shield's Provider Connection site at www.blueshieldca.com/provider. The ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format. The ERA replaces the paper Explanation of Payment. To enroll for the ERA, providers may enroll online or complete an enrollment form. Instructions are found on Provider Connection at www.blueshieldca.com/provider in the *Claims* section under *Enroll in EDI* or by contacting the EDI Help Desk at (800) 480-1221.

Once ERAs are set up, paper EOPs will be discontinued. However, you can always retrieve copies of EOPs from Provider Connection at www.blueshieldca.com/provider.

To enroll in the ERA/EFT program, please complete the enrollment forms found on Provider Connection. Input ERA Enrollment form in the search tool bar and hit the link for enrollment forms. Fax completed forms to (866) 276-8456.

For questions regarding the ERA/EFT enrollment process, please call the EDI Help Desk at (800) 480-1221.

> *Note:* When enrolling in the ERA/EFT program, you must register your National Provider Identifier (NPI) with Blue Shield of California.

Blue Shield Explanation of Payments (EOP) *(cont'd.)*

Calculating Member Liability

Blue Shield is in compliance with California Senate Bill 1085 (also known as the Mello Bill), which requires that the member copayment be based on the negotiated (allowed) or billed amount, whichever is less.

The following is an example of how payment is calculated for an inpatient claim. For questions or clarification about the payment or the EOB, call the member's service center number that appears on the EOB.

Step 1: Calculate the Negotiated amount

	$755.00	Per Diem
	x 6	Days
	$4530.00	

Step 2: Calculate member liability (deductible, coinsurance, copayment, and sanction) based on the billed charges or negotiated amount, whichever is less.

	$5255.95	Billed Charges
	$4530.00	Negotiated Amount

Because the negotiated amount is less than the total billed charges, the member liability is calculated using the negotiated amount.

	$4530.00	Negotiated Amount
Deductible	- $100.00	Deductible Amount
	$4430.00	
Copayment	x 20%	
	$886.00	Copayment Amount

Total Member Liability is calculated as the sum of the deductible, coinsurance, copayment, and sanction.

	$100.00	Deductible Amount
	+ $886.00	Copayment Amount
Total Member Liability:	$986.00	

Blue Shield Explanation of Payments (EOP) *(cont'd.)*

Calculating Member Liability *(cont'd.)*

Payment Totals:	$3544.00	Blue Shield payment
	+ 986.00	Member liability
	$4530.00	Total payment to facility

See Appendix 4-A for examples of payment calculations for outpatient services.

Contractual Adjustment Amount

EOBs report the contractual adjustment dollars to any participating provider. Contractual adjustment is the difference between the total billed charges and Blue Shield's allowed amount or contracted rate amount or usual and customary fee (a write-off amount). Having the contractual adjustment on the EOB will give an accurate amount for the provider's accounts receivable department. Also, along with the contractual adjustment amount, the EOB will have a message explaining what the amount is.

The new messages are as follows:

1. (Adjusted claim) - Your contractual adjustment is <insert #>
2. Your contractual adjustment is <insert #>

See examples for computing contractual adjustment:

Example 1: Negotiated Rate Facility

Claim billed amount: $1500.00
Contracted Allowed Amount: $1250.00
Total Contractual Adjustment: $250.00
Total Blue Shield (paid) amount: $1125.00

$1500.00	Facility's billed amount
- $1250.00	Contracted allowed amount
$250.00	Contractual adjustment amount
$1250.00	Allowed amount
- $125.00	Coinsurance
$1125.00	Blue Shield payment

Blue Shield Explanation of Payments (EOP) *(cont'd.)*

Contractual Adjustment Amount *(cont'd.)*

Example 2: Negotiated Rate Facility

Claim billed amount: $4000.00
Contracted Allowed Amount: 20% discount
Total Contractual Adjustment: $800.00
Total Blue Shield (paid) amount: $2880.00

$4000.00	Facility's billed amount
- $3200.00	Contracted allowed amount
$800.00	Contractual adjustment amount

$3200.00	Allowed amount
- $320.00	Coinsurance
$2880.00	Blue Shield payment

Check Issuance

Please notify Blue Shield immediately, in writing to the address below, if the remittance address of your hospital changes.

Blue Shield of California
Provider Information & Enrollment
P.O. Box 629010
El Dorado Hills, CA 95762-9010

Be sure to include your Blue Shield provider number on all billings and correspondence with us. Payments can be received electronically through Electronic Funds Transfer (EFT). Contact the EDI Help Desk at (800) 480-1221 for more information.

Calculating Allowed Amounts

In calculating allowed amounts, Blue Shield may round the figure to the nearest whole dollar.

Third Party Liability (TPL)

If a member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield and the hospital or facility will provide the necessary treatment according to plan benefits. If the member receives a related monetary award or settlement from the third party, third party insurer or from uninsured or underinsured motorist coverage, Blue Shield and the hospital or facility have the right to recover the cost of benefits paid for treatment of the injury or illness. The total amount of recovery will be calculated according to California Civil Code Section 3040.

The member is required to:

1. Notify Blue Shield and the hospital or facility in writing of any claims or legal action brought against the third party as a result of their role in the injury or illness within 30 days of submitting the claim or filing the legal action against the third party;
2. Agree to fully cooperate and complete any forms or documents needed to pursue recovery from the third party;
3. Agree, in writing, to reimburse Blue Shield for benefits paid from any recovery received from the third party;
4. Provide a lien calculated according to California Civil Code Section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Respond to information requests regarding the claim against the third party and notify Blue Shield and the hospital or facility in writing within ten (10) days of any recovery obtained.

If this plan is part of an employee welfare benefit plan subject to the Employee Retirement Income Security Act (ERISA), the member is also required to do the following:

1. Ensure that any monetary recovery is kept separate from the member's other assets and agree in writing that the amount necessary to satisfy the lien is held in trust for Blue Shield; and,
2. Instruct legal counsel retained by the member to hold the portion of the recovery to which Blue Shield is entitled in trust for Blue Shield.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is utilized when a member is covered by more than one group health plan. Payments for "allowable expenses" will be coordinated between the plans up to the maximum benefit value or amount payable by each plan separately.

COB ensures that benefits paid by multiple group health plans do not exceed 100% of eligible expenses and the plans follow a consistent order of payment.

Determining the Order of Payment

When a plan does not have a COB provision, that plan will provide its benefits first. Otherwise, the plan covering the person as an employee will provide its benefits before the plan covering the person as a dependent.

The following applies to coverage for dependent children:

- When the parents are not divorced or separated, the group health plan of the parent whose date of birth (month and day) occurs earlier in the year is primary. If either parent's plan does not have a COB provision regarding dependents, this rule does not apply. The rule established by the plan without a COB provision determines the order of benefits.
- When the parents are divorced or separated and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, that parent's group health plan is primary. The group health plan of the other parent is secondary.
- When the parents are not married, or are divorced or separated and there is no court order which would otherwise establish coverage for the child, primary responsibility is determined in the following order:
    1. The group health plan of the custodial parent.
    2. The group health plan of the spouse of the custodial parent.
    3. The group health plan of the non-custodial parent.
- When the parents are divorced or separated and there is a court decree that the parents share joint custody, without specifying which parent is responsible for the health care expenses of the child, the group health plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.

If the above rules do not apply, the plan that has covered the person for the longer period of time is the primary plan provided that:

- The group health plan covering the person, or the dependent of such person, as an active employee provides benefits before the group health plan that covers the person, or the dependent of such person, as a laid-off or retired employee. If either plan does not have a COB provision regarding laid-off or retired employees, this rule does not apply.

Coordination of Benefits *(cont'd.)*

When Blue Shield is the Primary Plan

The hospital or facility will provide Blue Shield Plan benefits without considering the existence of any other group health plan.

Upon request, the hospital or facility will provide the member or the secondary group health plan with a statement documenting copayments paid by the member or services denied so the member may collect the reasonable cash value of those services from the secondary group health plan. It is not necessary to provide the member with an itemized billing.

When Blue Shield is the Secondary Plan

If, as the secondary plan, the hospital or facility covers a service that would otherwise be the primary group health plan's liability, the hospital or facility may collect the reasonable cash value of that service from the primary group health plan.

When a disagreement exists as to which group health plan is secondary, or the primary group health plan has not paid within a reasonable period of time, Blue Shield will provide benefits as if it were the primary group health plan, provided the member:

- Assigns to Blue Shield the right to receive benefits from the other group health plan;
- Agrees to cooperate with Blue Shield in obtaining payment from the other group health plan; and
- Allows Blue Shield to verify benefits have not been provided by the other group health plan.

References

Additional information regarding COB is available through the following references:

- California Code of Regulations, Title 28, Section 1300.67.13
- The member's *Evidence of Coverage*

Limitations for Duplicate Coverage (Commercial)

Veterans Administration (VA)

The member's primary plan is required to pay the Veterans Administration (VA) for medically necessary plan benefits provided to the member who is a qualified veteran at a VA facility for a condition unrelated to military service (based on the reasonable value or Blue Shield's allowable amount). The VA claims cannot be denied solely because the member failed to obtain a referral or authorization.

If an issue arises as to whether an illness or injury is related to military service, the VA determination prevails. While the VA determination is not subject to review, the VA will, upon request, provide documentation to substantiate its decision.

If the member is treated by the VA, the VA notifies Blue Shield by sending a copy of an assignment of benefits and will cooperate with requests for medical records. The VA will accept payment equal to what would ordinarily be paid to other providers in its geographic area. Regular administrative procedures should be followed, as if the VA were part of the member's IPA/medical group.

Department of Defense (DOD) – TRICARE/CHAMPVA

Blue Shield is always primary (unless another group plan is primary) for covered services provided at a Department of Defense (DOD) facility when the member is not on active duty, even if for a condition related to military service. Payment is based on the reasonable value or Blue Shield's allowable amount. TRICARE - CHAMPVA will not provide payment if the services are a benefit through Blue Shield but were not paid because the member did not comply with service delivery rules (e.g., non-authorized out of network non-emergency/urgent services). TRICARE - CHAMPVA may cover other services excluded by Blue Shield.

Limitations for Duplicate Coverage (Commercial) *(cont'd.)*

Medi-Cal

Medi-Cal is considered a payor of last resort.

Medicare Eligible Members

1. Blue Shield will provide benefits **before** Medicare in the following situations:

    a. When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payor laws).

    b. When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payor laws).

    c. When the Member is eligible for Medicare solely due to end stage renal disease during the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.

2. Blue Shield will provide benefits after Medicare in the following situations:

    a. When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payor laws).

    b. When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payor laws).

    c. When the Member is eligible for Medicare solely due to end stage renal disease after the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.

    d. When the Member is retired and age 65 years or older.

When Blue Shield provides benefits after Medicare, the combined benefits from Medicare and the Blue Shield group plan may be lower but will not exceed the Medicare Allowed charges. The Blue Shield group plan Deductible and Copayments or Coinsurance will be waived.

Limitations for Duplicate Coverage (Commercial) *(cont'd.)*

Services for Members in Custody of the Penal System

Section 1374.11 of the Health & Safety Code prohibits health care plans from denying hospital, medical, or surgical services for the sole reason that the individual served is confined in a city or county jail, or is a juvenile detained in any facility if the individual is otherwise entitled to receive services. Blue Shield is also required to provide covered services when the member is injured during the act of committing a crime.

Transition of Care / Financial Responsibility Upon Enrollment/Disenrollment for Medicare Advantage Members

The following language is taken from the Code of Federal Regulations §422.322 Source of payment and effect of election of the MA plan election on payment, Federal Regulation §422.318, and Federal Register Part 412 - Prospective Payment Systems for Inpatient Hospital Services.

Transfers/Discharges

If a transfer from one inpatient area or unit within a facility to another unit within the same facility occurs during a member's hospitalization, this is a continuous admission, and the source of coverage and financial responsibility typically remains unchanged. (Does not apply for transfers to acute rehab, TCU, or SNF level of care.)

If a member is discharged from one facility and admitted to another during his/her hospitalization, the financial responsibility depends on the source of coverage at the time of the second admission.

A discharge indicates that one of the following has occurred:

- The member moves from a PPS level of care to a non-PPS level of care, such as to an acute rehab, TCU or SNF facility.
- The member is transferred to another PPS facility, typically representing a change in the level of care.
- The member is discharged from the acute inpatient facility.

Transition of Care / Financial Responsibility Upon Enrollment/Disenrollment for Medicare Advantage Members *(cont'd.)*

Prospective Payment System (PPS) Participating Hospitals, Skilled Nursing Facilities (SNF), Home Health Agency (HHA), etc.

Members hospitalized prior to their Effective Date with the Blue Shield Medicare Advantage plan.

- If a member is an inpatient in an acute hospital facility prior to his or her effective date with the Blue Shield Medicare Advantage plan, the member's *current* source of coverage at the time of admission is financially responsible for all medically necessary Medicare Part A (hospital) services through the date of discharge or through the date of transfer to an alternate facility. Blue Shield is not required to provide nor assume responsibility to pay for any inpatient services covered under Medicare Part A during the inpatient stay. Part B or physician services become a responsibility of the IPA/PCP/delegated group as of the member's effective date.
- Under the above circumstances Blue Shield Plan Providers will assume responsibility for inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay. Discharge to a skilled nursing facility is considered as an inpatient hospital discharge.

  Caution: Under the above rules, CMS has viewed a "transfer to an in-plan hospital" as a discharge in the past. This makes the Health Plan liable for the admission from the date of the transfer and Medicare pays the "transfer payment" to the facility to which the member was an inpatient at the time of admission.

Prospective Payment System (PPS) Participating Hospitals

Coverage Terminates While the Blue Shield Medicare Advantage Plan Member is Hospitalized.

If Blue Shield coverage terminates while the member is hospitalized, regardless of the reason for the termination, and the admission was authorized by the member's IPA/PCP, Blue Shield liability for inpatient hospital services will continue until the member is discharged. Responsibility for Part B/physician services ends on the member's disenrollment effective date.

Transition of Care / Financial Responsibility Upon Enrollment/Disenrollment for Medicare Advantage Members *(cont'd.)*

Non-Prospective Payment System (PPS) Hospitals

Although most hospitals are part of the Medicare Prospective Payment System, there are limited facilities, such as Children's hospitals that are excluded from PPS reimbursement. Should that be the case, the above rules do not apply if the hospital is not a PPS hospital. In cases where the member is in a non-PPS hospital the member's new source of coverage is financially responsible for all medically necessary services as of the enrollment/disenrollment date.

Skilled Nursing Facility

If a member is in a skilled nursing facility on the effective date of his/her enrollment/disenrollment, the member's new source of coverage is financially responsible for all medically necessary services as of the enrollment/disenrollment date.

Claim Inquires and Adjustments

Claim Inquiries

Blue Shield is committed to making payment within 30 days of receipt of a properly completed claim form. To check the status of an unpaid claim, refer to the following sections.

You can check the status of claims by accessing Provider Connection at www.blueshieldca.com/provider. or, you can check the status of a claim by transmitting a 276 electronic claim status transaction. Initial enrollment and testing are required for submitting electronic transactions. Please contact the EDI Help Desk at (800) 480-1221.

Claim Inquiries and Adjustments *(cont'd.)*

Electronic Claim Submission

Blue Shield acknowledges receipt of a claim within two calendar days of the receipt of the claim. If you do not receive payment or notification after 10 days from the original claim submission, you can:

- Check the status of claims by accessing Provider Connection;
- Transmit an EDI 276 electronic claim status transaction; (for more information on transmitting EDI 276 transactions please contact the EDI Help Desk at (800) 480-1221); or
- Call the member's assigned service center (shown on the member's ID card). For claims with dates of service less than 30 days old, Customer Service will refer the provider to Provider Connection where this information is readily accessible.

If Blue Shield cannot locate the claim, check your Blue Shield of California EDI Acknowledgement Reports (i.e., TA1, 999, 277CA) or your clearinghouse/billing service proprietary reports subsequent to the date you transmitted your claim to determine if the claim was rejected prior to entering Blue Shield's processing system.

- Create another claim (include any late charges with this copy of the claim) and resubmit claim electronically.
- Blue Shield will process your tracer for payment if we check our files and are unable to find any record of your original billing.
- Please contact our EDI Help Desk at (800) 480-1221 before resubmitting a claim if not found rejected on reports.

Claim Inquiries and Adjustments *(cont'd.)*

Paper Submission (When Medical Records are Required)

Providers can, within 15 calendar days of Blue Shield's receipt of the claim, verify receipt of a claim by contacting Customer Services. If you do not receive payment or notification within 30 days from the original claim submission, you can:

- Check the status of claims by accessing Provider Connection
- Transmit an EDI 276 electronic claim status transaction; or
- Call the member's assigned service center (shown on the member's ID card).

If Blue Shield cannot locate the claim, providers may wish to submit a tracer. Please allow a minimum of 30 days from the original submission date before sending a tracer as the *Explanation of Benefits* (EOB) and the inquiry may simply have crossed in the mail. To initiate a tracer, providers must:

- Prepare a legible copy of the original claim and check it for clerical errors or omissions, which may have delayed payment. Add any late charges to this copy of the claim and include detailed supporting information.
- Mail the tracers in an envelope, separate from your regular claims to the member's assigned service center or the appropriate regional service center.

Providers may use their own tracer form if it contains the following information:

- Facility name
- Blue Shield provider
- Member name
- Member ID number
- Date of admission
- Patient name
- Date Blue Shield was
- Dates of service on your
- Total dollars billed

It is always best to attach a legible copy of the original billing in case Blue Shield cannot find a record of the original claim.

Claim Inquiries and Adjustments *(cont'd.)*

Paper Submission (When Medical Records Required) *(cont'd.)*

Late Charges

Electronic Submission

Submit late charges and adjustment/corrected claims electronically.

- Wait until the original claim is finalized.
- Create a new line with the date the late charges were incurred by entering the value of "5" in the third digit of the Type of Bill field (Form Locator 4). This identifies the claim as late charges only.
- Resubmit the claim electronically.

Once the initial claim has finalized in our system, resubmit the Late Charges claim with the appropriate adjustment bill type. You will also need to include the following EDI segments on the adjusted claim:

- Send "5" in CLM05-3 (Loop 2300) to indicate Late Charges of Prior Claim

  Sample: CLM✻12345656✻500✻✻✻11:A:5✻Y✻A✻Y✻I~

- Send "F8" in REF01 (Loop 2300)
- Send the 12-digit claim number from the incorrect original claim in REF02 (Loop 2300).

  Sample: REF*F8*123456789123~

Note: 123456789123 should be replaced with the original claim number. Obtain the Blue Shield claim number via the claim status option on Provider Connection, from the explanation of benefits (EOB), or from the electronic remittance advice (ERA).

Paper Submission (When Required)

- Wait until the original claim is finalized.
- Print a legible copy of the late charges indicating type of bill xx5 for late charges.
- Submit the claim(s) to the appropriate address.
- Ensure the request is within the timely filing period as specified in the contract.

Claim Inquiries and Adjustments *(cont'd.)*

Resubmissions or Corrected Claims/Adjustments

Resubmission

If a claim needs to be resubmitted because you have not received notice of adjudication, use the following steps:

- Confirm that the claim has not been received by accessing Provider Connection at www.blueshieldca.com/provider.
- Transmit a 276 electronic claim status transaction
- If the original claim was not received, resubmit the claim electronically.

Corrected Claims

Submit corrected claims electronically to Blue Shield. Please wait for the original claim to finalize before sending a corrected claim to avoid denial as a duplicate.

Once the initial claim has finalized in our system, resubmit the corrected claim with the appropriate adjustment bill type. Corrected claims should be submitted within 365 days from the claim finalized date unless otherwise specified in the contract. You will also need to include the following EDI segments on the adjusted claim:

- Send "7" in CLM05-3 (Loop 2300) to indicate Replacement of Prior Claim

  Sample: CLM✻12345656✻500✻✻✻11:A:7✻Y✻A✻Y✻I~

- Send "F8" in REF01 (Loop 2300)
- Send the 12-digit Blue Shield Payer Claim Control Number from the incorrect original claim in REF02 (Loop 2300).

  Sample: REF*F8*123456789123~

Note: 123456789123 should be replaced with the original claim number. Obtain the Blue Shield claim number via the claim status option on Provider Connection, from the explanation of benefits (EOB), or from the electronic remittance advice (ERA).

Ensure the request is within the timely filing period as specified in the contract.

Note: Submit corrected claims originally processed by a Foundation for Medical Care directly to that Foundation.

Claim Inquiries and Adjustments *(cont'd.)*

Resubmissions or Corrected Claims/Adjustments *(cont'd.)*

Important Information

Corrected claims submitted with no documentation clearly describing the correction being made may be processed as a raw claim or returned with a request for additional information regarding the change(s).

Timely Submission of Claims and Disputes

Claims appeals by providers must be in writing and must specify the basis for the appeal. Particular payment or procedural issues that are in question must be cited. Unless otherwise specified in your contract, the following time frames for submission of claims and appeals will apply:

- **New claims:** Within 180 calendar days, or the time specified in your contract, whichever is greater, from the last date of service or discharge date.
- **Claims requiring coordination of benefits with another carrier:** Within 120 calendar days of the primary carrier's payment determination
- **Initial Disputes:** Within 365 calendar days of the last Blue Shield payment or decision, or the time specified in your contract, whichever is greater
- **Final Disputes:** Within 65 working days of Blue Shield's initial determination or the time specified in your contract, whichever is greater.

Note: Blue Shield will deny any claims or disputes that are not submitted within these time frames.

Provider Inquiries

A provider inquiry is a telephonic or written request to explain the rationale for a decision to reduce, delay, or deny services or benefits. An inquiry may also include questions or clarifications regarding proposed services or treatments, administrative procedures or claims payment. Issues or questions may be resolved at the inquiry level. An inquiry may or may not alter the original decision.

Providers may initiate inquiries regarding a decision by Blue Shield, including but not limited to a claims processing determination.

Inquires may focus upon areas such as:

- Payment Methodology
- Multiple Surgeries
- Corrected Billings
- Medical Policy
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Utilization Denials

Inquiries can be generated by either a telephone call or written correspondence to the member's appropriate Customer Service Department. For claims with dates of service less than 30 days old, visit Provider Connection at www.blueshieldca.com/provider where this information is readily accessible. Information about the Provider Dispute Resolution Process and where to direct an inquiry can be found in this manual or by contacting the member's Customer Service Department.

Provider Dispute Resolution

Blue Shield has established fair, fast, and cost-effective procedures to process and resolve provider disputes. Blue Shield's Provider Dispute Resolution Process is accessible to both contracting and non-contracting providers.

Definitions

Bundled Provider Dispute

A written notice to Blue Shield, submitted to the designated provider dispute address or digital online portal, identifying a group of substantially similar multiple claims challenging, appealing, or requesting reconsideration of claims that have been previously denied, adjusted (paid at less than billed charges), or contested, or requesting resolution of billing determinations, such as bundling/unbundling of claims/procedures codes allowances, or requests for reimbursement of an overpayment of a claim; that are individually numbered using the Blue Shield assigned claim number to identify each claim contained in the bundled dispute; or a group of substantially similar contractual disputes that are individually numbered using the section of the contract and sequential numbers that are cross-referenced to a document or spreadsheet. (For example, Section I A #1, Section I A #2, etc.)

Date of Contest, Denial, Notice, or Payment

The date Blue Shield's claim decision, or payment, is electronically transmitted (835) or deposited in the U.S. mail (*Explanation of Benefits*).

Determination Date

The working day when the written provider dispute determination or amended provider dispute determination is delivered by physical or electronic means.

Good Cause for Untimely Submission of Claims

Circumstances reasonably beyond the control of the provider that prevented the timely submission of a claim would be considered "good cause."

Examples of circumstances beyond the control of the provider, include, but are not limited to:

- Patient gave incorrect health coverage/insurance information (copy of an incorrect ID card);
- Patient was unable to provide health coverage/insurance information (patient was comatose, the patient expired before the information could be obtained, etc.);
- Natural disaster/acts of nature (fire, flood, earthquake, etc.);
- Acts of war/terrorism;
- System wide loss of computer data (system crash);
- BlueCard claims sent to the wrong Blue Plan.

Provider Dispute Resolution *(cont'd.)*

Definitions *(cont'd.)*

Good Cause for Untimely Submission of Claims *(cont'd.)*

Examples of circumstances that **do not** constitute "good cause":

- Claim was sent to the wrong carrier (Blue Cross instead of Blue Shield), but the provider had the correct health coverage/insurance information for Blue Shield of California membership.
- The claim was submitted timely, but Blue Shield was unable to process because the claim was not a complete claim (did not contain the minimum data elements to enter the claim into the system, i.e., missing a subscriber number).

Providers have an obligation to be responsible for appropriate timely billing practices. Provider requests to review a claim timely filing denial because the provider believes there was good cause for the delay, will be handled as a provider dispute.

Provider Dispute

A written notice to Blue Shield, submitted to the designated provider dispute address or digital online portal, challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted (paid at less than billed charges), or contested, or requesting resolution of billing determinations, such as bundling/unbundling of claims/procedures codes or allowances, requests for reimbursement of an overpayment of a claim; administrative policies and procedures, administrative terminations, retro-active contracting, or any other contract issue.

Provider Inquiry

A telephone or written request for information, or question regarding claim status, submission of corrected claims, member eligibility, payment methodology rules (bundling/unbundling logic, multiple surgery rules), Medical Policy, coordination of benefits, or third party liability/workers compensation issues submitted by a provider to Blue Shield, or a telephone discussion or written statement questioning with the way Blue Shield processed a claim (i.e., wrong units of service, wrong date of service, clarification of payment calculation).

Receipt Date

The working day when the provider dispute is first delivered to the designated Provider Dispute Office, post office box, or portal by physical or electronic means.

Unfair Billing Pattern

Engaging in a demonstrable and unjust pattern of bundling/unbundling or up-coding of claims, and/or other demonstrable and unjustified billing patterns.

Provider Dispute Resolution *(cont'd.)*

Definitions *(cont'd.)*

Unjust or Unfair Payment Pattern

Any practice, policy, or procedure that results in repeated delays in the processing and/or correct reimbursement of claims as defined by applicable regulations.

Unfair Billing and Payment Patterns

Reporting Unfair Billing Patterns

Blue Shield may report *providers* Blue Shield believes are engaging in unjust billing patterns to the DMHC.

Toll-free provider line **(877) 525-1295**
E-mail: plans-providers@dmhc.ca.gov

Providers may report instances in which the provider believes a *plan* is engaging in an unfair payment pattern to the DMHC's Office of Plan and Provider Relations.

Toll-free provider line **(877) 525-1295**
E-mail: plans-providers@dmhc.ca.gov

Unfair Payment Patterns

Unjust payment patterns include:

- Imposing a claim filing deadline on three or more claims over the course of any three-month period, or less than 90 days for contracting providers; 180 days for non-contracting provider; 90 days from the primary payor's determination, when paying as a secondary/tertiary payor.
- Failing to forward at least 95% of misdirected, capitated claims to the appropriate capitated entity within 10 working days of receipt, over the course of any three-month period.
- Failing to accept at least 95% of late claim submissions, over the course of any three-month period, when the provider submits proof of Good Cause.
- Failing to notify providers at least 95% of the time, in writing and within 365 days of the payment date of intent to recover an overpayment, over the course of any three-month period.
- Failing to notify providers, at least 95% of the time over the course of any three-month period, of the claim, name of the patient, date of service and a clear explanation of the basis upon which an overpayment was made.

Provider Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Unfair Payment Patterns *(cont'd.)*

- Failing to allow providers 30 working days, at least 95% of the time over the course of any three-month period, of their right to dispute a request to recover an overpayment.
- Failing to acknowledge at least 95% of claims within 2 working days for electronic submissions, or 15 working days for paper submissions.
- Failing to provide an accurate and clear written explanation of the specific reasons for denying, adjusting, or contesting a claim at least 95% of the time over any three-month period.
- Including provider contract provision inconsistent with any of the applicable regulations of the Health and Safety Code or CCR, title 28 on three (3) or more occasions over the course of any three-month period.
- Requesting medical records on more than 3% of claims, excluding professional emergency services and care claims, over the course of any 12-month period.
- Requesting medical records on professional emergency services and care claims on more than 20% of the claims, over the course of any 12-month period.
- Failing to process PPO and POS II, III claims within 30 working days or HMO and POS I claims within 45 working days at least 95% of the time over the course of any three-month period.
- Failing to automatically pay interest penalties when processing exceeds the specified time frames at least 95% of the time over the course of any three-month period.
- Failing to notify providers of the provider dispute process when a claim is denied, adjusted, or contested at least 95% of the time over the course of any three-month period.
- Failing to acknowledge initial provider disputes within 15 working days of receipt at least 95% of the time over the course of any three-month time period.
- Failing to resolve and provide written determination of initial provider disputes within 45 working days of receipt.
- Rescinding or modifying an authorization for health care services after the provider has rendered the service on three or more occasions over the course of any three-month period.

Provider Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Provider Contracts

Blue Shield informs contracting providers and capitated entities, initially upon contracting, or upon change of the Provider Dispute Resolution Process, of the procedures for submitting a provider dispute, including:

- Identity of the office responsible for receiving and resolving provider disputes
- Mailing address
- Telephone number
- Directions for filing a provider dispute
- Directions for filing bundled provider dispute
- The timeframe in which Blue Shield will acknowledge receipt of the provider dispute. The disclosures are made in contracts, in the various provider manuals and on Provider Connection at www.blueshieldca.com/provider.

Explanation of Benefits

An *Explanation of Benefits* (EOB) informs providers of the availability of Blue Shield's Provider Dispute Resolution Process and provide instructions for filing a provider dispute. An EOB is sent each time Blue Shield processes a provider submitted claim unless a provider is enrolled with Electronic Remittance Advice (ERA). Providers can retrieve a copy of the EOB from Provider Connection at www.blueshieldca.com/provider. The provider dispute resolution information is printed on page two of the provider's EOB. EOBs are issued to both contracted and non-contracted providers.

Online Access

The Provider Dispute Resolution Process is available to registered users on Provider Connection at www.blueshieldca.com/provider.

Provider Manuals

The Provider Dispute Resolution Process is documented in the *Hospital and Facility Guidelines, Independent Physician and Provider Manual,* and the *HMO IPA/Medical Group Procedures Manual.*

Provider Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Blue Shield's Provider Dispute Process

The following information outlines the process Blue Shield has established to allow providers and capitated entities to submit provider disputes.

Blue Shield's Provider Dispute Resolution Department is responsible for the Provider Dispute Resolution Process.

Blue Shield's Senior Management is responsible for:

- The maintenance of the Provider Dispute Resolution Process;
- Review of the Provider Dispute Resolution operations;
- Noting any emerging patterns to improve administrative capacity, Blue Shield Provider Relations, claim payment procedures and patient care; and
- Preparing the required reports and disclosures.

Provider Disputes – Reports

Blue Shield will track each provider dispute and will report the following information in the Annual Plan Claims Payment and Dispute Resolution Mechanism Report:

- Information on the number and type of provider disputes received.
- A summary of the disposition of all provider disputes, including a description of the types, terms, and resolution.

Internally, Blue Shield will review the provider dispute data to identify emerging patterns and trends and initiate the appropriate action.

Levels

Blue Shield's Provider Dispute Resolution Process consists of two levels: Initial and Final.

CCR, Title 28, Section 1300.71.38 requires health plans to offer a provider dispute resolution process. State law does not require health plans to offer two levels of dispute.

Provider Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

How to Submit a Provider Dispute

A provider dispute may be submitted online or by mail, for information on how to submit a dispute please visit Provider Connection at www.blueshieldca.com/en/provider/claims/disputes.

Required Information/Provider Dispute

A provider dispute must contain the following information:

- The provider's name
- The provider's identification number and/or the provider's tax identification number
- Contact information – mailing address and phone number
- Blue Shield's claim number, when applicable
- The patient's name, when applicable
- The patient's Blue Shield subscriber number, when applicable
- The date of service, when applicable
- A clear explanation of issue the provider believes to be incorrect, including supporting medical records when applicable
- Proof of participation in the IPA's provider dispute process and when the original determination was made by the IPA (such as a copy of the IPA Dispute denial letter and/or denial letter EOB), when applicable

As applicable, bundled disputes must identify individually each item by using either the claim number or the section of the contract and sequential numbers that are cross-referenced to a document or spreadsheet.

Provider Disputes Submitted With Incomplete Information

Disputes that are lacking the required information will be returned to the provider or capitated entity.

Blue Shield will return the dispute and notify the provider or capitated entity of the missing information necessary to categorize the submission as a provider dispute.

The original dispute, along with the additional information identified by Blue Shield, should be resubmitted to Blue Shield within 30 working days of the provider's receipt of the notice requesting the missing information.

Blue Shield will not require the provider to resubmit claim information or supporting documentation that has been previously received as part of the claim adjudication process.

Provider Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Timeframe for Submitting Provider Disputes

Initial provider disputes must be submitted within 365 days, or the time specified in the provider's contract, whichever is greater, of Blue Shield's date of contest, denial, notice or payment.

In the event the dispute is regarding the lack of a decision, the dispute must be submitted within 365 days, or the time specified in the provider's contract, whichever is greater, after the time for contesting or denying a claim has expired.

Provider disputes alleging a demonstrable and unfair payment pattern by Blue Shield must be submitted within the timeframes indicated above, based on the date of the most recent action or inaction by Blue Shield.

Timely Filing of Provider Disputes

If a contracted provider or capitated entity fails to submit an initial dispute or final dispute within the required timeframes, the provider or capitated entity:

- Waives the right for any remedies to pursue the matter further
- May not initiate a demand for arbitration or other legal action against Blue Shield
- May not pursue additional payment from the member.

In instances where the provider's contract specifies timeframes that are greater than the timeframes specified in Blue Shield's Provider Dispute Resolution process, the provider's contract takes precedence.

Blue Shield will review the untimely submission of a provider dispute when the provider's contract includes a good cause clause for the untimely submissions of provider disputes.

Timeframe for Providers to Contest Blue Shield's Request to Refund an Overpayment

Providers must submit notice contesting Blue Shield's refund request within 30 working days of the receipt of the notice of overpayment.

The provider's notice contesting Blue Shield's refund request must include the required information for submitting a provider dispute as well as a clear statement indicating why the provider believes that the claim was not overpaid. A provider's notice that it is contesting Blue Shield's refund request will be identified as a provider dispute and handled in accordance with Blue Shield's Provider Dispute Resolution Process.

Provider Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Timeframe for Acknowledgement of Provider Disputes

Blue Shield will acknowledge the receipt of each dispute submission. Paper disputes are acknowledged within 15 working days and electronic submissions are acknowledged within 2 working days.

Timeframe for Resolving Provider Disputes

Blue Shield will resolve disputes within 45 working days of the receipt of the dispute.

In the event the original dispute was returned to the provider due to missing information, the amended dispute will be resolved within 45 working days of the receipt of the amended dispute.

If the resolution of the provider dispute results in additional monies due to the provider, Blue Shield will issue payment, including interest when applicable, within 5 working days of the date of the written response notifying the provider of the dispute resolution.

Resolution

Blue Shield will provide a written determination to each provider dispute, stating the pertinent facts and explaining the reason(s) for the determination.

The written determination of an initial dispute will notify providers and capitated entities of their right to file a final dispute.

Submitting Appeals on a Member's Behalf

Appeals submitted on a member's behalf will be treated as a member grievance and handled within the member grievance process.

Blue Shield will verify with the member that the provider has been authorized to submit an appeal (member grievance) on the member's behalf.

Provider Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Final Provider Disputes

Provider or capitated entities that disagree with Blue Shield's written determination may pursue the matter further by initiating a final dispute.

Providers and capitated entities may submit a final dispute within 65 working days of Blue Shield's initial determination, or the time specified in the provider's contract, whichever is greater. For information on how to submit a final dispute, please visit Provider Connection at www.blueshieldca.com/en/provider/claims/disputes.

The final dispute must be submitted in accordance with the required information for a provider dispute.

Blue Shield will, within 45 working days of receipt, review the final dispute and respond in writing, stating the pertinent facts and explaining the reason(s) for the determination.

Arbitration

If, after participating in the initial and final levels of the Provider Dispute Resolution Process, the provider or capitated entity continues to disagree with Blue Shield's payment or determination, the provider or capitated entity may submit the matter to binding arbitration as applicable and outlined in the provider's contract.

Capitated Entity (IPA/Medical Group/Capitated Hospital) Provider Dispute Resolution Requirements

IPA/Medical Group and Capitated Hospital Responsibilities

In accordance with state law, IPA/medical groups and capitated hospitals are required to establish a fair, fast, cost-effective provider dispute resolution process.

In the event an IPA/medical group or a capitated hospital fails to resolve provider disputes in a timely manner, consistent with state law, Blue Shield may assume responsibility for the administration of the IPA/medical group's or capitated hospital's dispute resolution mechanism.

Capitated Entity (IPA/Medical Group/Capitated Hospital) Provider Dispute Resolution Requirements *(cont'd.)*

Blue Shield Contracts

Blue Shield contracts require the IPA/medical group and capitated hospitals to establish and maintain a fair, fast, and cost-effective dispute resolution to process and resolve provider disputes.

The IPA/medical group and capitated hospital's dispute resolution process must be in accordance with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36 1371.37 1371.38, 1371.4, and 1371.5 of the Health and Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of the CCR, Title 28.

Quarterly Reports

IPAs, medical groups, and capitated hospitals are required to create and retain for audit a tabulated report of each provider dispute received and/or reported. The report must be categorized by receipt date, and include the identification of the provider, type of dispute, disposition and outcome of the dispute and number of work days to resolve the dispute. A summary statistical report will be submitted quarterly in accordance with ICE-standardized formats.

Each individual dispute in a bundled dispute is reported separately.

Provider Dispute Documentation

Upon request, the IPA/medical group and capitated hospital will make available to Blue Shield, or the DMHC, all records, notes and documents regarding their provider dispute resolution mechanism and the resolution of provider disputes. Providing all supporting documentation at the time the initial dispute is submitted will help ensure timely processing.

Medical Necessity Denials

Blue Shield's Provider Dispute Resolution Process includes a process to allow any provider submitting a claim dispute to the IPA/medical group and/or capitated hospital's dispute resolution mechanism involving an issue of medical necessity or utilization review and unconditional right of appeal for that claim dispute.

Providers must submit their request to Blue Shield within 60 working days from the date they received the IPA/medical group and/or capitated hospital's determination.

Provider Disputes of Medicare Advantage Claims

Providers retain the right to dispute any initial claim decision by submitting a request for redetermination. For Medicare Advantage disputes the submission may be submitted online or by mail, for information on how to submit a dispute please visit Provider Connection at www.blueshieldca.com/en/provider/claims/disputes.

Required Information/Dispute

A dispute must be submitted in writing and contain the following information:

- The provider's name
- The National Provider Identifier (NPI) and/or the provider's tax or social security number)
- Contact information – valid mailing address and phone number
- Blue Shield's Internal Control Number (ICN)/Claim number
- The patient's name
- The patient's Blue Shield subscriber number
- The date of service
- A clear explanation of issue the provider believes to be incorrect, including supporting medical records, when applicable
- Proof of participation in the IPA's provider dispute resolution process and when the original determination was made by the IPA (such as a copy of the IPA Dispute denial letter and/or denial letter EOB)

Timeframe for Submitting Disputes

Disputes must be submitted within 365 calendar days, or the time specified in the provider's contract, whichever is greater, of Blue Shield's date of contest, denial, notice or payment.

If a contracted provider or capitated entity fails to submit an initial provider dispute within the required timeframes, the provider or capitated entity:

- Waives the right for any remedies to pursue the matter further
- May not initiate a demand for arbitration or other legal action against Blue Shield
- May not pursue additional payment from the member

In instances where the provider's contract specifies timeframes that are greater than the timeframes specified in Blue Shield's Provider Dispute Resolution process, the provider's contract takes precedence.

Blue Shield will review the untimely submission of a provider dispute when the provider's contract includes a good cause clause for the untimely submissions of provider disputes.

Provider Disputes of Medicare Advantage Claims *(cont'd.)*

Resolution

Blue Shield will, within 60 calendar days of receipt of the provider request for redetermination, review the dispute and respond to the physician or provider using the Provider Dispute Resolution letter or the Remittance advice with either additional payment or an explanation for upholding the original claim determination.

The provider must have a process in place to handle all contracted provider requests for redetermination, resolving them in a timely manner, and in accordance with contractual agreements following CMS regulations.

Non-Contracted Providers

CMS requires Medicare Advantage Organizations (MAO) to apply the provider dispute resolution process for payment disputes between non-contracted and deemed providers. Non-contracted and deemed providers are defined as follows:

- A non-contracted provider is one that was not aware the patient was a private fee-for-service member at the time of service, e.g., an emergency situation.
- A deemed provider is one who was aware that the patient was a private fee-for-service member at the time of service, and therefore had the ability to view the plan's terms and conditions of payment.

Note: The provider dispute resolution process for payment disputes between non-contracted and deemed providers does not include Part D claims (Prescription Drug Plans).

Provider disputes include any decisions where a non-contracted/deemed provider contends that the amount paid by the organization (MAO) for a covered service is less than the amount that would have been paid under original Medicare. The disputes may also include instances where there is a disagreement between a non-contracted/deemed provider and the organization about the plan's decision to pay for a different service than that billed. An example would include down-coding.

Provider Disputes of Medicare Advantage Claims *(cont'd.)*

Non-Contracted Providers *(cont'd.)*

A provider has the right to dispute a reimbursement decision made by an MAO Plan. A provider has the right to request a reconsideration of payment denials, within 65 calendar days for $0 payments and within 120 calendar days for underpayments following receipt of the initial determination or decision.

Providers who wish to submit a dispute must also submit a signed Waiver of Liability (WOL) statement holding the member harmless regardless of the outcome of the dispute. Providers should include documentation such as a copy of the original claim, remittance notification showing the denial and any clinical records and other documentation that supports the provider's argument for reimbursement. If there is no WOL submitted, the plan will make three attempts to request the WOL. If the WOL is not submitted after 3 attempts and before the 60th calendar day, the plan may dismiss the provider dispute.

If additional information is required to process the dispute, Blue Shield will make an attempt to obtain the necessary documentation. If the additional documentation is not received within 60 calendar days from the dispute receipt date, Blue Shield will conduct a review based on what is available.

Blue Shield will resolve the appeal within 60 calendar days of the receipt of the dispute. In the event that the additional payment is warranted in favor of the provider and was due to an error by Blue Shield, interest will be included along with the additional payment.

After the MAO Plan makes its Payment Review Determination (PRD) decision, all Medicare non-contracted zero payment denials are auto forwarded to the Independent Review Entity (IRE). For non-contracted Medicare/ Duals underpayments, providers can contact 1-800-Medicare. For cases that are dismissed, the provider has the right within 180 days to ask the plan to vacate (set aside) the dismissal action if the plan determines there is good cause to vacate. The provider also has the right to ask for an independent reviewer contracted with Medicare to review the decision to dismiss the appeal request within 60 calendar days to Maximus Federal Services, Inc.

To dispute the provider organization's decision upholding initial payment, the provider must submit a request online or by mail, for information on how to submit a dispute please visit Provider Connection at www.blueshieldca.com/en/provider/claims/disputes.

This page intentionally left blank.

Section 5: Blue Shield Benefit Plans and Programs

This page intentionally left blank.

Table of Contents

This page intentionally left blank.

Blue Shield Benefit Plans

Blue Shield offers a variety of benefit plans representing a cross section of financing and delivery systems to meet the various health care needs and budgets for subscribers of both group plans and individual plans.

This section gives a brief description of the following Blue Shield plans. More detailed plan information, including plan networks, can be found on www.blueshieldca.com/provider.

- HMO Plans
- PPO Plans
- Medicare Advantage Plans
- Point of Service (POS) Plans
- Federal Employee Program (FEP) PPO
- Medicare Supplement Plans
- The BlueCard® Program
- Other Payors

Blue Shield HMO Plans

Blue Shield offers the Access+ HMO® Plan and Local Access+ HMO Plan to Small Business, Core Accounts, and Premier Account groups. Point-of-service (POS) plans are included in the Core and Premier HMO family of products. Blue Shield offers Trio HMO plans to Small Business, Core, Premier and Individual and Family Plans (IFP).

Access+ *Specialist*℠ and Trio+ *Specialist* Feature

HMO members with the Access+ or Trio+ *Specialist* feature can self-refer directly to any primary care physician (PCP) or specialist (M.D. or D.O.) for a consultation, as long as that physician is in the same IPA/medical group as the member's PCP.

The members simply present their ID card at the specialist's office and pay their specialist office visit copayment.

After the consultation, if additional services or procedures are recommended, the specialist coordinates care with the member's PCP and follows Blue Shield's authorization process. If Blue Shield authorizes additional services/procedures, the HMO member may go back to the specialist for the authorized services and pay the usual office visit copayment.

Blue Shield HMO Plans *(cont'd.)*

Access+ Specialist℠ and Trio+ *Specialist* Feature *(cont'd.)*

An Access+ and Trio+ *Specialist* visit does not include:

- Any services which are not covered, or which are not medically necessary
- Services provided by a non-Access+ provider (such as podiatry and physical therapy), except for the X-ray and laboratory services described above
- Allergy testing
- Endoscopic procedures
- Any diagnostic imaging, including CT, MRI, or bone density measurements
- Injectables, chemotherapy or other infusion drugs, other than vaccines and antibiotics
- Infertility services
- Emergency services
- Urgent services
- Inpatient services, or any services which result in a facility charge, except for routine X-ray and laboratory services
- Services for which the IPA/medical group routinely allows the member to self-refer without authorization from the primary care physician
- OB/GYN services by an obstetrician/gynecologist or family practice physician within the same IPA/medical group as the member's PCP

Custom employer groups may choose not to offer this direct access feature. The member's identification card will designate if the member has the Access+ or Trio+ *Specialist* feature. An "A+" appears next to the network name on the Access+ HMO card and a "T+" appears next to the network name on the Trio HMO card.

Blue Shield Medicare Advantage Plans

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

To be eligible for enrollment in a Blue Shield Medicare Advantage plan program, the member must have both Medicare Part A and Medicare Part B and live within the CMS-approved Blue Shield Medicare Advantage plan service area. On May 22, 2020, CMS issued a Final Rule that permits enrollment of individuals with End Stage Renal Disease (ESRD) in MA-PD plans, effective January 1, 2021, as long as they meet the Medicare Advantage carriers' eligibility criteria.

The Blue Shield Medicare Advantage plan provides comprehensive coordinated medical services to members on a prepaid basis through an established provider network. With a Medicare Advantage HMO plan, members must choose a primary care physician (PCP) and have all care coordinated through this physician. The Blue Shield Medicare Advantage (HMO) plans are regulated by the Centers for Medicare & Medicaid Services (CMS), the same federal agency that administers Medicare. Please contact Blue Shield Medicare Advantage Customer Service (877) 654-6500 (for Providers), (800) 776-4466 (for Members), if you have questions about benefit information, eligibility, claims, and/or billing.

Medicare Part D

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

Medicare Part D *(cont'd.)*

Part D Eligibility

In general, an individual is eligible to enroll in a MA-PD or PDP plan if:

1. The individual is entitled to Medicare Part A and/or enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and/or Part B as of the effective date of coverage under the plan; and
2. The individual permanently resides in the service area of a MA-PD or PDP.

Other eligibility requirements and exclusions include:

- An individual who is living abroad or is incarcerated is not eligible for Part D.
- For individuals whose Medicare entitlement determination is made retroactively, Part D eligibility begins with the month the individual receives the notice of the Medicare entitlement determination.
- A MA-PD or PDP sponsor may not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in a PDP and continues to be enrolled in his/her employers or spouse's health benefits plan, then coordination of benefits (COB) rules will apply.
- A Part D eligible individual may not be enrolled in more than one Part D plan at the same time.

Fraud, Waste, and Abuse Requirements and Training

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

The Medicare Part D FWA training is a requirement under CMS for anyone who works with Medicare Part D. Blue Shield's Medicare Part D Compliance training is for contracted pharmacies to ensure these providers have a thorough understanding of federal and state regulations around Medicare Part D. Successful completion is required of anyone involved with the administration or delivery of the Part D benefit. The training focuses on how to detect, correct, and prevent fraud, waste, and abuse surrounding Medicare Part D. To access the online training, please go to www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.

Medicare Part D *(cont'd.)*

Exclusion Lists

CMS prohibits any employee, provider, contractor, or subcontractor from performing any activity related to Medicare Part D or other federal programs if they are listed in the General Services Administration (GSA) database of excluded individuals/entities, located online at www.sam.gov or the Office of Inspector General's (OIG) database of excluded individuals or entities, located at oig.hhs.gov under *Exclusions*.

CMS requires that all entities review the list prior to hiring or contracting of anyone and monthly thereafter to ensure that its employees, board members, officers, and first tier entities, downstream entities, or related entities that assist in the administration or delivery or Part D benefits are not included on such lists. If the first tier entities, downstream entities, or related entities are on such lists, the Sponsor's policies shall require the immediate removal of such employees, board members, or first tier entities, downstream entities, or related entities from any work related directly or indirectly on all federal health care programs and take appropriate corrective actions.

Medicare Part D Prescriber Preclusion List

The Centers for Medicare & Medicaid Services (CMS) is eliminating the prescriber and provider enrollment requirement for Part C and Part D and instead is compiling 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. (c) Have been convicted of a felony under federal or state law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program.

CMS will make 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.

Additionally, the added provisions require organizations offering Part D to cover a three-month provisional supply of the drug and provide beneficiaries with individualized written notice before denying a Part D claim or beneficiary request for reimbursement on the basis of a prescriber's being neither enrolled in an approved status nor validly opted out. The three-month provisional supply is intended to give the prescriber time to enroll in Medicare or opt-out and ensure beneficiary access to prescribed medication.

Medicare Part D *(cont'd.)*

Medication Therapy Management Program (MTMP)

Blue Shield provides a Medication Therapy Management Program (MTMP) for its Medicare Part D members to assist them in managing their chronic conditions. The Blue Shield MTMP is for members meeting all of the following criteria:

- Have three of the following conditions:
  - Alzheimer's Disease
  - Bone diseases – arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis)
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Dyslipidemia
  - End-stage renal disease (ESRD)
  - Human immunodeficiency virus/Acquired immunodeficiency syndrome (HIV/AIDS)
  - Hypertension
  - Mental Health (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions)
  - Respiratory Disease (including asthma. chronic obstructive pulmonary disease (COPD), and other chronic lung disorders)
- Receive eight or more different covered Part D maintenance medications monthly
- Likely to incur an annual cost threshold established by CMS each calendar year for Medicare covered prescriptions

Members meeting these criteria will be automatically enrolled in the MTMP at no additional cost relating to the program and they may opt-out if they desire.

Members have the option to speak with a designated pharmacist to discuss their medication therapy issues. The pharmacist consultations are designed to improve member health while controlling out-of-pocket costs and may include topics such as:

- Drug adverse reactions
- Drug side-effects
- Drug-drug interactions
- Drug-disease interactions
- Medication non-compliance and non-adherence
- Duplicate therapy
- Dosing that can be consolidated
- Non-prescription drug use

A written summary of the consultation with relevant assessments and recommendations will be provided to the member. The member's prescribing physician or primary care physician may be contacted by the pharmacist to coordinate care or recommend therapy changes when necessary.

Blue Shield PPO Plans

Blue Shield offers the following types of PPO Plans and networks:

- Full PPO is Blue Shield's largest PPO network available to the Small Business, Core Accounts, and Premier Accounts groups and provides full California statewide coverage.
- Exclusive PPO is Blue Shield's PPO network available to the Individual and Family Plan (IFP) members and provides full California statewide coverage.
- Tandem PPO is Blue Shield's narrow network built around many of our ACO partnerships and provides California statewide coverage. It is available to Small Business, Core Accounts, and Premier Accounts groups
- Virtual Blue PPO plans provide access to virtual primary care and specialist care, including psychiatry and psychology. A care team consisting of a virtual PCP, health coach and behavioral health specialist help members get the care they need. When in-person care is either preferred by the member or referred to by the care team, members have access to both in network and out of network health care professionals and facilities as outlined above. These are available to Small Business, Core Accounts, and Premier Accounts groups
- PPO Savings Plans are high deductible health plans designed to allow qualified individuals to establish a tax advantaged account under federal guidelines. Most services provided by a preferred hospital provider require a percentage copayment. These are available to Small Business, Core Accounts, and Premier Accounts groups.

Under a Blue Shield PPO plan, members may self-refer to any provider. The highest benefits level (i.e., lowest out-of-pocket costs) will be paid when a Blue Shield Preferred Provider is used.

A member's copayment and deductible amounts for covered services will vary depending on whether they select a preferred hospital provider or a non-network hospital provider. Therefore, there is a financial incentive for members to use Blue Shield preferred hospital providers.

If a member chooses to go to a non-network hospital provider, Blue Shield's payment for a service by that non-network hospital provider may be substantially less than the amount billed. The member is responsible for the difference between the amount Blue Shield pays and the amount billed by non-network hospital provider. It is therefore to the member's advantage to obtain medical and hospital services from preferred hospital providers.

Blue Shield Medicare Advantage PPO Plans

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

To be eligible for enrollment in the Blue Shield Medicare (PPO) program, the member must have both Medicare Part A and Medicare Part B and live within the CMS-approved Blue Shield Medicare (PPO) service area. On May 22, 2020, CMS issued a Final Rule that permits enrollment of individuals with End Stage Renal Disease (ESRD) in MAPD plans, effective January 1, 2021, as long as they meet the Medicare Advantage carriers' eligibility criteria.

The Blue Shield Medicare (PPO) MAPD and MA only plans include individual and group plans. Listed below are the contract numbers and the service areas for 2025:

- H4937-001 Blue Shield Select (PPO) (Alameda County)
- H4937-002 Blue Shield Select (PPO) (Orange/San Diego Counties)
- H4937-801 Blue Shield Medicare (PPO) (Group MAPD PPO, calendar year renewal)
- H4937-802 Blue Shield Medicare (PPO) (Group MAPD PPO, non-calendar year renewal)
- H4937-803 Blue Shield Medicare without Rx (PPO) (Group MA-only PPO, calendar year renewal)
- H4937-804 Blue Shield Medicare without Rx (PPO) (Group MA-only PPO, non-calendar year renewal)
- H4937-805 CCPOA Medical Plan Medicare (PPO) (for CCPOA Group MAPD PPO only, calendar year renewal)

The Blue Shield Medicare (PPO) plan members may self-refer to any provider. The highest benefits level (i.e., lowest out-of-pocket costs) will be paid when a Blue Shield Medicare Preferred Provider is used. A member's copayment and deductible amounts for covered services will vary depending on whether he or she selects a preferred hospital provider or a non-network hospital provider. Therefore, there is a financial incentive for members to use Blue Shield Medicare preferred hospital providers.

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

The Blue Shield Medicare (PPO) plan is regulated by the Centers for Medicare & Medicaid Services (CMS), the same federal agency that administers Medicare. Please contact Blue Shield Medicare Customer Service (877) 654-6500 (for Providers), (800) 776-4466 (for Members), if you have questions about benefit information, eligibility, claims, and/or billing.

Blue Shield Medicare (PPO) Service Area

The definition of a service area, as described in the Blue Shield Medicare (PPO) *Evidence of Coverage* (EOC), is the geographic area approved by the CMS in which a person must permanently reside to be able to become or remain a member of a Blue Shield Medicare (PPO) plan. Blue Shield Medicare (PPO) has one service area within the state. The specific service area in which the member permanently resides determines the Blue Shield Medicare (PPO) plan(s) in which the member may enroll. Members who temporarily move outside of the service area (as defined by CMS as six months or less) are eligible to receive emergency care and urgently needed services outside the service area.

Blue Shield Medicare (PPO) Benefits

Premiums and Copayments or Coinsurance

Medicare Premiums

All Blue Shield Medicare (PPO) members (individual and group) must continue paying their Medicare Part B premium. The Medicare Part B premium is either deducted from their monthly Social Security or Railroad Retirement Board annuity check or is paid directly to Medicare by the member or someone on his/her behalf (i.e., the Medi-Cal program).

The Affordable Care Act requires Part D enrollees with higher income levels to pay a monthly adjustment amount, the Part D Income Related Monthly Adjustment Amount (IRMAA). This IRMAA applies to all Medicare beneficiaries, both group and individual, who fall into higher income levels. The Part D IRMAA is paid directly to the government and, like the Part B premium, may be deducted from the monthly Social Security or Railroad Retirement Board annuity check or paid directly to Medicare by the member or someone on his/her behalf.

Failure to pay either the Medicare Part B premium or Part D IRMAA will result in the member being involuntarily disenrolled from Blue Shield's Medicare Advantage plan, both individual and group.

Plan Premiums

Blue Shield Medicare (PPO) individual plans have a monthly plan premium. Please refer to the Blue Shield Medicare (PPO) individual Summary of Benefits for additional plan premium information.

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

The monthly plan premium for Blue Shield Medicare (PPO) group plans are determined through an actuarial-based pricing process and model which Underwriting uses to develop the rates. Plan premiums vary by employer group.

Copayments or Coinsurance

Blue Shield Medicare (PPO) members must pay a copayment or coinsurance for certain services. Please refer to the Blue Shield Medicare (PPO) individual or group Summary of Benefits for additional copayment or coinsurance information.

Pharmacy Copayments or Coinsurance

Copayment or coinsurance amounts vary by the Blue Shield Medicare (PPO) individual or group plan, as well as by the tier placement of the covered medication and whether the member obtains the medications from a network pharmacy with preferred cost-sharing, an out-of-network pharmacy, a network pharmacy with standard cost-sharing, or the home delivery pharmacy.

Inpatient Benefits

Blue Shield Medicare (PPO) individual and group plans provide benefits for treatment in hospitals and skilled nursing facilities (SNFs) and extend the basic benefits provided by Medicare. Blue Shield Medicare (PPO) individual and group plans provide coverage according to Medicare guidelines.

In addition to hospital care, Blue Shield Medicare (PPO) individual and group members who meet Medicare guidelines for skilled nursing facility care have coverage for SNF benefits. Please refer to the Blue Shield Medicare (PPO) Summary of Benefits for the number of days covered for care provided by a skilled nursing facility.

Outpatient Benefits

Blue Shield Medicare (PPO) individual and group plans cover all outpatient medical services according to Medicare guidelines. Outpatient medical services are provided and paid for the diagnosis or treatment of illness and injury when they are considered to be reasonable and medically necessary. Please refer to the Blue Shield Medicare (PPO) Summary of Benefits (sent separately to IPA/medical groups) for a list of covered outpatient services.

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Outpatient Prescription Drugs

Blue Shield Medicare (PPO) individual and group plans provide coverage for plan-approved generic and brand name prescription medications included in the Blue Shield Medicare (PPO) Drug Formulary. The formulary may vary by plan, by plan service area, or by employer group. The formulary for group plan members includes some drugs that are "excluded" drugs per CMS. The employer groups may choose to cover some of these excluded drugs as part of their additional supplemental coverage. Some formulary medications may require prior authorization or step therapy. The Blue Shield Medicare (PPO) utilization management criteria can be found within the plan drug search tools located at www.blueshieldca.com/en/home/be-well/pharmacy/drug-formularies. Prescriptions from non-plan providers are covered only if issued in conjunction with covered emergency services and filled through a network pharmacy.

The formulary contains medications approved by the Food & Drug Administration (FDA) which are subject to a rigorous clinical review by clinical pharmacists and physicians to evaluate comparative safety, comparative efficacy, likelihood of clinical impact, cost-effectiveness when safety and efficacy are similar. The Pharmacy & Therapeutics (P&T) Committee determines formulary decisions and medication coverage policies consistent with the currently accepted medical evidence and standards. The Blue Shield P&T Committee has oversight responsibility for pharmaceutical/utilization management programs, drug utilization review programs, and other drug-related matters impacting patient care. The voting members of the P&T Committee include actively practicing network physicians and clinical pharmacists who are not employees of Blue Shield. The P&T Committee determines formulary status and/or medication coverage policies for drugs covered in the prescription benefit on at least a quarterly basis.

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Outpatient Prescription Drugs *(cont'd.)*

In general, outpatient prescription drugs are covered under Blue Shield Medicare (PPO) when they are:

- Included in the Blue Shield Medicare (PPO) Drug Formulary. (Blue Shield may periodically add, remove, and/or make changes to coverage limitations on certain drugs, or alter the member price of a drug. If Blue Shield implements a formulary change that limits member ability to fill a prescription, Blue Shield will notify affected enrollees in advance of the change.)
- Prescribed by a provider (a doctor, dentist, or other prescriber) who either accepts Medicare or has filed documentation with CMS showing that he or she is qualified to write prescriptions.
- Filled at a Blue Shield Medicare (PPO) network pharmacy.
- Used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by the following CMS-approved references: the *American Hospital Formulary Service Drug Information*; the *DRUGDEX Information System*; the *USPDI*; and the *National Comprehensive Cancer Network and Clinical Pharmacology*, or their successors.

Network Retail Pharmacy – A pharmacy where members can get their prescription drug benefits. They are termed "network pharmacies" because they contract with our plan. In most cases, member prescriptions are covered only if they are filled at one of our network pharmacies.

Standard Cost-Sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Preferred Cost-Sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs that members get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Non-Formulary Outpatient Prescription Drugs

If a drug is not listed in the Blue Shield Medicare (PPO) individual or group drug formulary, the prescriber or member may contact Blue Shield Medicare (PPO) Customer Service to confirm the drug's coverage status.

If Member Services confirms that the drug is not part of the Blue Shield Medicare (PPO) individual or group drug formulary and not covered, the member has two options:

- The member can ask the prescriber to prescribe a different drug, one that is part of the Blue Shield Medicare (PPO) individual or group drug formulary.
- The member can request that Blue Shield make a Formulary Exception (a type of Coverage Determination) to cover the specific drug.

If a member recently joined Blue Shield and is taking a drug not listed in the Blue Shield Medicare (PPO) Drug Formulary at the time he/she joined, the member may be eligible to obtain a temporary supply. For more information, please refer to the next section, which reviews the rules that govern dispensing temporary supplies of a non-formulary drug.

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Non-Formulary Outpatient Prescription Drugs *(cont'd.)*

Transition Policy

New Blue Shield members may be taking drugs not listed in the Blue Shield Medicare (PPO) individual or group drug formulary, or the drug(s) may be subject to certain restrictions, such as prior authorization or step therapy. Members are encouraged to talk to their doctors to decide if they should switch to an appropriate drug in the plan formulary or request a Formulary Exception (a type of Coverage Determination) in order to obtain coverage for the drug. While these new members may discuss the appropriate course of action with their doctors, Blue Shield may also cover the non-formulary drug or drug with a coverage restriction in certain cases during the first 90 days of new membership.

For each of the drugs not listed in the formulary or that have coverage restrictions or limits, Blue Shield will cover a temporary 30-day supply (unless the prescription is written for fewer days) when the new member goes to a Network Pharmacy (and the drug is otherwise a "Part D drug"). After the first 30-day supply, Blue Shield will not pay for these drugs, even if the new member has been enrolled for less than 90 days.

If a member is a resident of a long-term-care facility (LTC) such as a nursing home, Blue Shield will cover supplies of Part D drugs in increments of 14 days or less for a temporary 31-day transition supply (unless the prescription is written for fewer days) during the first 90 days a new member is enrolled in our Plan beginning on the member's effective date of coverage. A transition supply notice will be sent to the member within 3 business days of the first incremental transition fill. If the LTC resident has been enrolled in our Plan for more than 90 days and needs a non-formulary drug or a drug that is subject to other restrictions, such as step therapy or dosage limits, Blue Shield will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception. For members being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to the formulary, and such enrollees are allowed to access a refill upon admission or discharge.

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Non-Formulary Outpatient Prescription Drugs *(cont'd.)*

Prescribers should submit persuasive evidence in the form of studies, records, or documents to support the existence of the situations listed above. To request prior authorization, please contact:

Blue Shield of California
Pharmacy Services
601 12th Street, 21st Floor
Oakland, California 94607

Pharmacy Services is available by phone at (800) 535-9481, Monday through Friday, 8 a.m. to 6 p.m. PST, excluding holidays. Faxed requests may be sent to (888) 697-8122 at any time or requests may be submitted electronically through the electronic health record, if available. Prescribers who have questions regarding formulary or non-formulary drugs and/or need a copy of the formulary can call the number above or go to www.blueshieldca.com and navigate to the *Provider Connection* or *Pharmacy* page.

Once all required supporting information is received, a coverage decision based upon medical necessity is provided within 24 hours for an expedited review and 72 hours for standard requests.

Vision Services

Blue Shield Medicare (PPO) individual and group plans cover vision services that meet Medicare guidelines.

In addition to Medicare-covered services, all Blue Shield Medicare (PPO) individual and some group plans cover routine (non-Medicare covered) eye examinations/screenings. For individual plans, services are provided through VSP Vision Care. Refer to the Blue Shield Medicare (PPO) Summary of Benefits for benefit guidelines.

Hearing Services

Blue Shield Medicare (PPO) individual and group plans cover hearing exams in accordance with Medicare guidelines. Please refer to the member's Blue Shield Medicare (PPO) Summary of Benefits for additional information.

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Optional Buy-Up Services (Group Members Only)

Blue Shield Medicare (PPO) also offers optional buy-up benefits for hearing, vision, podiatry, chiropractic, and acupuncture that offer routine coverage beyond what is covered by Medicare. In addition, Silver Sneakers Fitness is available. These benefits are not part of the standard plan offering and may be available at an additional cost when selected by the employer group/union. If purchased, they must be made available to all Blue Shield Medicare (PPO) GMAPD members within that employer group/union. (There are also optional buy-up dental plans being offered to Blue Shield Medicare (PPO) individual plan members.)

Exclusions to Blue Shield Medicare (PPO) Benefits

General Benefit Exclusions

Blue Shield files benefits with CMS on an annual basis. Coverage for the following benefits, services, and conditions are **excluded** from coverage under the Blue Shield Medicare (PPO) Plan, effective January 1, 2025:

- Services considered not reasonable and necessary according to the standards of Original Medicare unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment, and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in a member's hospital room or a skilled nursing facility room, such as a telephone or a television.
- Full-time nursing care in the member's home.
- Custodial care unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps members with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by the member's immediate relatives or members of their household.

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

Exclusions to Blue Shield Medicare (PPO) Benefits *(cont'd.)*

General Benefit Exclusions *(cont'd.)*

- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Routine preventative and diagnostic dental care, such as exams, cleanings and x-rays are covered by the Blue Shield Medicare (PPO) plan. Additional non-routine dental care, such as fillings, dentures and others are covered only when the member is enrolled in the optional supplemental dental PPO benefit plan
- Routine foot care, except for the limited coverage provided according to Medicare guidelines or as specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Orthopedic shoes unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Routine hearing exams, hearing aids, or exams to fit hearing aids, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy, and low vision aids unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Routine acupuncture, except for chronic low back pain, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Naturopath services (uses natural or alternative treatments).

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

Exclusions to Blue Shield Medicare (PPO) Benefits *(cont'd.)*

General Benefit Exclusions *(cont'd.)*

- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, Blue Shield will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Immunizations for foreign travel purposes.

The plan will not cover the excluded services listed above. Even if members receive the services at an emergency facility, the excluded services are still not covered.

Prescription Drug Benefit Exclusions

Blue Shield files benefits with CMS on an annual basis. The following exclusions apply to the Blue Shield Medicare (PPO) prescription drug benefits:

- Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Drugs purchased outside the United States and its territories are not covered.
- Off-label use of prescription drugs is usually not covered. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Generally, coverage for "off-label use" is allowed only when the use is supported by the following CMS-approved references: the *American Hospital Formulary Service Drug Information,* the *DRUGDEX Information System*, for cancer the *National Comprehensive Cancer Network and Clinical Pharmacology,* and *Lexi-Drugs* or their successors. If the use is not supported by one of these reference sources, then our plan cannot cover its "off-label use."
- By law, the following categories of drugs are not covered by Medicare drug plans:
    - Non-prescription drugs (also called over-the-counter drugs).
    - Drugs related to assisted reproductive technology (ART).
    - Drugs when used for the relief of cough or cold symptoms.
    - Drugs when used for cosmetic purposes or to promote hair growth.
    - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
    - Drugs when used for the treatment of sexual or erectile dysfunction (ED).

Blue Shield Medicare Advantage PPO Plans *(cont'd.)*

Exclusions to Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Prescription Drug Benefit Exclusions *(cont'd.)*

- Drugs that are prescribed for medically-accepted indications other than sexual or erectile dysfunction (such as pulmonary hypertension) are eligible for Part D coverage.
- Drugs when used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

National Medicare Coverage Determinations

A National Coverage Determination (NCD) is a national policy determination made by CMS regarding the coverage status of a particular service under Medicare. A NCD does not include a determination of what code, if any, is assigned to a service or a determination about the payment amount for the service.

National Medicare Coverage Determinations that arise between contract years allow Medicare Advantage Organizations and contracted providers to bill Medicare on a fee-for-service basis for newly covered items that exceed the significant cost criterion.

When the significant cost criterion is not met:

- The MAO is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date of the NCD or as of the date specified in the legislation/regulation.

When the significant cost criterion is met:

- The MAO is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the significant cost of the service or benefit. However, a plan must pay for the following:
  - Diagnostic services related to the NCD item, service, or legislative change in benefits and most follow-up services related to the NCD item, service, or legislative change (42 CFR § 422.109(c)(2)(i),(ii));
  - NCD items, services, or legislative change in benefits that are already included in the plan's benefit package either as Original Medicare benefits or supplemental benefits.

National Medicare Coverage Determinations *(cont'd.)*

Billing to Medicare must include a notice that the item being billed involves a new coverage issue and that the person or organization submitting the bill is requesting fee-for-service reimbursement.

For select medications, Blue Shield Medicare PPO Medication Policies and Step Therapy requirements may also apply. The Blue Shield Medicare (PPO) benefit for medication coverage under the benefit can be found on Provider Connection at www.blueshieldca.com/provider under *Authorizations*, *Clinical policies and guidelines*, and then *Medication Policy.*

For more information on NCDs, go to the Medicare Coverage Database on the CMS website at www.cms.gov/medicare-coverage-database/search.aspx.

Blue Shield Point-of-Service (POS) Plans

The POS plans combine both HMO and PPO service delivery features. At the time services are needed, or at the point of service, the member may choose to receive benefits under the HMO network or PPO network option. Under the latter option, the member may receive covered services from either a Blue Shield preferred hospital provider or non-network hospital provider. The choice determines the member's level of financial responsibility.

Point-of-Service (POS) Options

Network	How Care is Accessed	Financial Responsibility
HMO Network	Member's care is coordinated through the primary care physician who makes any necessary specialist referrals.	Physician and hospital services: Applicable HMO office visits and other copayments apply. No deductible unless the plan has a facility deductible which would be applied for applicable inpatient admissions.
PPO In-network	Member self-refers to a Blue Shield Preferred Provider.	Applicable PPO copayment and deductible applies.
Non-Network PPO (non-preferred or non-participating)	Member self-refers to a non-network provider.	Applicable PPO copayment and deductible applies. Member may be balance-billed.

Upon enrollment in the POS Plan, all members must select a primary care physician (PCP). Services rendered by the PCP or specialist and facility care authorized by the PCP are deemed to be provided under the HMO option. Facility claims for such HMO options should be submitted on a UB 04 (or successor) form.

Blue Shield Point-of-Service (POS) Plans *(cont'd.)*

Point-of-Service (POS) Options *(cont'd.)*

Services provided on a "self-referred" basis – either by a physician who is not the member's PCP, by a specialist, or other provider without a referral from the member's PCP – will be paid according to the provider's agreement with Blue Shield.

When hospital services are provided under the PPO option, the facility should use the UB 04 (or successor) form for submitting a claim, mark it "self-referred" and send it to the appropriate Service Center. Blue Shield physicians should admit patients to a select or preferred hospital and follow the PPO pre-admission guidelines (refer to Section 3: Medical Care Solutions).

Federal Employee Program (FEP) (PPO)

About the BlueCross and BlueShield Service Benefit Plan

The local BlueCross and BlueShield Plans underwrite and administer the BlueCross and BlueShield Service Benefit Plan, the largest privately underwritten health insurance contract under the Federal Employee Health Benefits (FEHB) Program. Sixty-four percent of all federal employees and retirees who receive their health care benefits through the government's FEHB Program are members of the Service Benefit Plan.

Federal Employee Program (FEP) Preferred Providers include Blue Shield's Preferred Physicians and Elevance Blue Cross' Preferred Hospitals. FEP members may select the FEP Blue Focus, Basic Option or Standard Option benefit level. Under the Standard Option, members can seek care from any covered provider they want, however, in some cases, they must get advance approval of care from Blue Shield. FEP Blue Focus Members and Basic Option Member's must seek care from in-network providers to be covered for any services. The Blue Cross Blue Shield Service Benefit Plan Brochure is located at FEPBlue.org as well as medical and medication policies. Important FEP phone numbers are as follows:

- Blue Shield of California FEP Customer Service (800) 824-8839.
- Blue Shield of California FEP Integrated Care Management (800) 995-2800
- Blue Shield of California FEP Utilization Management and Prior Authorization (800) 633-4581
- Elevance Blue Cross of California FEP Customer Service (800) 322-7319

Federal Employee Program (FEP) (PPO) *(cont'd.)*

About the BlueCross and BlueShield Service Benefit Plan *(cont'd.)*

Under both the FEP Blue Focus and Basic Option plans, members must use Preferred providers in order to receive benefits, except under the following special circumstances. In addition, certain types of care must be approved in advance.

- Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d) Emergency services and accidents
- Professional care provided at preferred facilities by non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons
- Laboratory and pathology services, X-rays and diagnostic tests billed by non-preferred laboratories, radiologists, and outpatient facilities
- Services of assistant surgeons
- Special provider access situations, other than those described above. We encourage the member to contact Blue Shield of California for more information in these types of situations before they receive services from a non-preferred provider.
- Care received outside the United States, Puerto Rico, and the U.S. Virgin Islands

Unless otherwise noted above, when services of non-preferred providers are covered in a special exception, benefits will be provided based on the plan allowance. Members are responsible for the applicable coinsurance or copayment and may be responsible for any difference between Blue Shield's allowance and the billed amount.

Note: Please refer to Section 3 of the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure for more information on special circumstances.

Federal Employee Program (FEP) *(cont'd.)*

Precertification for Inpatient Hospital Admissions

Preferred providers are responsible for obtaining precertification for all inpatient admissions to preferred hospitals. Precertification requires notification prior to scheduled admissions or within two business days after an emergency admission, even if the member has been discharged from the hospital within those 2 days. The member will be subject to a $500 benefit reduction if admitted to a preferred hospital and precertification is not obtained. The member is ultimately responsible for ensuring that precertification has been completed. If the precertification is not obtained, the member's inpatient hospital benefit for covered services will be reduced by $500. (For specific rules, please refer to Section 3 the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure located at FEPBlue.org).

Precertification is not needed for a maternity admission for a routine delivery. However, if the mother's medical condition requires her to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, the physician or the hospital must contact Blue Shield for precertification of additional days. Further, if the baby stays after the mother is discharged, then the physician or the hospital must contact Blue Shield for precertification of additional days for the baby.

> *Note:* When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

Federal Employee Program (FEP) *(cont'd.)*

Mental Health and Substance Use Disorder Services for FEP

It is important to follow these policies to help ensure your patient's needs for mental health and substance use disorder services are met efficiently. Please use the following information to request assistance:

- For any services that are to be rendered in a residential treatment center (RTC), please call (800) 995-2800 **before** services are rendered. Services in a RTC are a covered benefit, when medically necessary, for members who are enrolled. A case manager will be able to assist you and the member to develop a plan that meets the member's needs.
- For mental health and substance use disorder inpatient hospitalizations call (800) 633-4581. If the admission is emergent due to a condition that puts the member's life in danger or could cause serious damage to bodily function, the member, the member's representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if the member has been discharged from the hospital. If we are not telephoned within two business days, a $500 penalty may apply.

No prior authorization is required for outpatient professional services, including individual or group therapy, outpatient partial hospitalizations, intensive outpatient programs, office, telehealth, or home visits for FEP PPO members. For questions regarding coverage, please call FEP Customer Services at (800) 824-8839. For questions regarding prior authorization, call the FEP Prior Authorization Department at (800) 633-4581.

Required Prior Authorization

Members must obtain prior approval for these services under both the Standard and Basic Option. Precertification is also required if the service or procedure requires an inpatient hospital admission. Contact Blue Shield at the prior authorization number (800) 633-4581 before receiving these types of services. Find more information about the services below in the BCBSA Service Benefit Plan (SBP) Brochure at www.fepblue.org/benefit-plans/benefit-plans-brochures-and-forms.

Federal Employee Program (FEP) *(cont'd.)*

Required Prior Authorization *(cont'd.)*

Prior Approval is required for:	Additional Information
Air Ambulance Transport (Non-Emergent)	Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval.
All Genetic Testing	All Genetic Testing requires prior authorization.
Applied behavior analysis (ABA)	Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
Gender affirmation surgery	Prior to surgical treatment of gender dysphoria, the provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and is later modified. Modification can be to the type of treatment, date, time, or location of the service/surgery to be provided.
Gene Therapy and Cellular Immunotherapy	Including Car-T and T-cell receptor therapy.
Hearing aids	Prior approval is required to receive coverage for prescription hearing aids. Over-the-counter hearing aids are not covered.
High-Cost Drugs	We require prior approval for certain high-cost drugs obtained outside of a pharmacy setting. Contact the customer service number on the back of your ID card or visit us at www.fepblue.org/highcostdrugs for a list of these drugs.
Hospice care	Prior approval is required for home hospice, continuous home hospice, or inpatient hospice care services. Blue Shield will advise you which home hospice care agencies we have approved. Please contact FEP Care Management at (800) 995-2800.
Mail Order Prescription Drug Program	Standard Option members may use our Mail Service Prescription Drug Program to fill their prescriptions. Basic Option members with primary Medicare Part B coverage also may use this program once prior approval is obtained.
Medical foods covered under the pharmacy benefit	Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: (800) 624-5077 for the hearing impaired) to request prior approval.
Outpatient sleep studies performed outside the home	Prior approval is required for sleep studies performed in any other location that is not the member's home.

Prior Approval is required for:	Additional Information
Prescription drugs and supplies	Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: 800-624-5077 for the hearing impaired) or visit the FEP CareMark website at www.caremark.com/wps/portal/WEBSUPPORT_FAQS?cms=CMS-PWCM-2034779 to request prior approval, or to obtain a list of drugs and supplies that require prior approval. *Note*: Updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change.
Proton Beam Therapy	Prior approval is required for all proton beam therapy services except for members aged 21 and younger, or when related to the treatment of neoplasms of the nervous system including the brain and spinal cord; malignant neoplasms of the thymus; Hodgkin and non-Hodgkin lymphomas.
Rehabilitation Services	Acute Rehab, Cardiac Rehab and Pulmonary Rehab.
Reproductive Services	Prior approval is required for intracervical insemination (ICI), intrauterine insemination (IUI), intravaginal insemination (IVI), and assisted reproductive technologies (ART).
Sperm/Egg Storage	Prior approval is required for the storage of sperm and eggs for individuals facing iatrogenic infertility.
Stereotactic body radiation therapy	Stereotactic body radiation therapy.
Stereotactic Radiosurgery	Prior approval is required for all stereotactic radiosurgery except when related to the treatment of malignant neoplasms of the brain, and of the eye specific to the choroid and ciliary body; benign neoplasms of the cranial nerves, pituitary gland, aortic body, or paraganglia; neoplasms of the craniopharyngeal duct and glomus jugular tumors; trigeminal neuralgias, temporal sclerosis, certain epilepsy conditions, or arteriovenous malformations.
Surgical services	The surgical services on the following list require prior approval for care performed by Preferred, Participating/Member, and Non-participating/Non-member professional and facility providers: - Surgery for severe obesity; Note: Benefits for the surgical treatment of severe obesity – performed on an inpatient or outpatient basis – are subject to the pre-surgical requirements listed in our medical policy at www.fepblue.org/legal/policies-guidelines. - Surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof, and floor of mouth except when care is provided within 72 hours of the accidental injury.

Prior Approval is required for:	Additional Information
Transplants – Prior approval is required for both the procedure and the facility	Prior Approval is required for all transplants, except cornea and skin. Covered Organ/tissue Transplants - See the list of covered transplant services in the Blue Cross Blue Shield Service Benefit Plan Brochure. If you travel to a Blue Distinction Center for Transplants, prior approval is also required for travel benefits. The organ transplant procedures must be performed in a facility with a Medicare-Approved Transplant Program. For Medicare's approved programs, go to https://qcor.cms.gov/main.jsp If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply, and you may use any covered facility that performs the procedure. *Note*: For the purposes of the blood or marrow stem cell clinical trial transplants covered under this Plan, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board (IRB) of the FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility where the procedure is to be performed. Clinical trials for certain blood or marrow stem cell transplants – See the list of conditions covered only in clinical trials in the Blue Cross Blue Shield Service Benefit Plan Brochure. All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact Blue Shield at the customer service telephone number listed on the back of their ID card before obtaining services.

Federal Employee Program (FEP) *(cont'd.)*

Integrated Care Management Program for FEP

Nurses who are licensed and familiar with California resources will be assisting your patients with obtaining the resources they require to maintain their optimum health. The referral phone number is (800) 995-2800.

Our Integrated Care Management program offers a systematic application of processes and shared information to optimize the design and coordination of benefits and care for members identified with acute or complex conditions. Through comprehensive, high-touch, coordinated care management delivered in partnership with providers, clients, and members, the program promotes improved health outcomes, quality of life, and member satisfaction.

Conditions managed through our Integrated Care Management Program include:

- Acute Catastrophic – Includes members with immediate needs relating to an acute episode of care for conditions such as stroke, septicemia, spinal cord injury, trauma, amputation, open wounds, newly diagnosed cancer, or complications from surgeries characterized by readmission to the hospital.
- Disease Management – Blue Shield provides disease management services to our members identified with chronic medical conditions, such as; Asthma, Diabetes, CHF, Chronic Obstructive Pulmonary Disease (COPD) and Coronary Artery Disease (CAD). Chronic diseases, including cardiovascular disease and diabetes, are the leading causes of death in California and are among the most common, costly, and often preventable of health problems. Disease management is an approach to reach members with chronic conditions and provide them with the necessary tools to minimize the impact of their condition. In 2025 Blue Shield will add the following list of Rare Disease Management to the current list of diagnosis above: Amyotrophic Lateral Sclerosis, Crohn's Disease, Cystic Fibrosis- adult and pediatric, Hemophilia, Systemic Lupus Erythematosus, Multiple Sclerosis, Myasthenia Gravis, Myositis, Parkinson's Disease, Rheumatoid Arthritis, Scleroderma, Seizure Disorders, and Sickle Cell Disease adult and pediatric.
- Post-neonatal Intensive Care Unit (NICU)/Pediatrics – Focuses on premature or medically complex neonates being discharged home from the hospital after birth, as well as pediatric members with special needs.
- Behavioral Health – Assists members with Mental Health and Substance Use Disorder diagnosis. Participates in discharge planning for all inpatient mental health and substance use disorder admissions, including detoxification.
- Oncology – Focuses on members with cancer diagnoses to manage them through the health care continuum.

Federal Employee Program (FEP) *(cont'd.)*

Integrated Care Management Program for FEP *(cont'd.)*

- Palliative Care – Provides a care management option for patients that includes symptom control in addition to curative therapy. A combination of palliative care while curative care is ongoing has been shown to improve quality of life, reduce inpatient stays, increase choice of hospice and the results have been demonstrated in both a care delivery locus and in a health plan setting. The intent of the program is to permit the use of palliative care for severe chronic conditions one year in advance of the patient's likely end of life.

Transitions of Care Program for FEP

Blue Shield's Transitions of Care program focuses on members and caregivers who need guidance on the transition to and from hospital and home. Unplanned readmissions are prevented by completing a safety risk assessment with the member, discussing follow-up plans, medication reconciliation, and facilitating adherence to the prescribed treatment plan. Length of hospital stay is decreased by preparing member for hospital stay and development of a discharge plan. The referral phone number is (800) 995-2800.

The Transitions of Care program has four primary components:

- A telephone call to the member by a Transitions of Care Nurse (TCN) to discuss the surgery/acute condition, what to expect, what to ask their physician, and how to prepare for the return home.
- A complimentary link to a Guided Imagery Toolkit is provided to members prior to or following surgery that weave together inspirational music, healing images, and positive statements to help add to a member's sense of safety and comfort prior to and following surgery.
- A recovery guide that provides members with useful information regarding what to ask their physician such as pre- and post-operative testing and preparation, expected post-operative recovery milestones, and information regarding return to work.
- A post-hospitalization call to identified patients who are urgently or emergently admitted to an acute care hospital. The TCN will discuss adherence to the discharge plan, provide medication reconciliation, and conduct a needs assessment for any unmet needs the patient may have post discharge. Additionally, the TCN may engage in care coordination efforts with the member when any unmet needs that have been identified may need further intervention.

Medicare Supplement Plans

Claims Assignment

For physician providers who accept assignment, Blue Shield pays contract benefits up to Medicare's approved amounts. Patients are responsible for payment of services not approved by Medicare. For physician providers who do not accept assignment, Blue Shield will pay according to the following structure for Medicare Supplement Plans:

Plan and Group Numbers	Medicare Unassigned Claims
Benefit Plan A, B, C, D, H, K	Patients pay balance of billed charges (limiting charge).*
Benefit Plan F, G, I, J	Blue Shield pays 100% of the difference between Medicare's payment and billed charges.
Golden Coronet Senior	Blue Shield pays 80% of the difference between Medicare's payment and billed charges. Patients pay balance of billed charges.*
Coronet Major Medicare	Patients pay balance of billed charges (limiting charge).*
Coronet Senior	Patients pay balance of billed charges(limiting charge). *
Preferred Senior	Patients pay balance of billed charges (limiting charge).*

**Not to exceed the Medicare limiting charge or billed charge, whichever is less.*

Note: Preferred Senior contracting physicians agree to accept Medicare assignment for Preferred Senior Plan members. Contracting Preferred Senior Anesthesiologists bill the Preferred Senior Plan directly under the Advance Pay System.

The BlueCard® Program

The BlueCard® Program is a national program that enables Blue Cross and Blue Shield (BCBS) Plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield Plan's service area. The program links participating healthcare providers with all the independent Blue Cross and Blue Shield Plans across the country through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

The BlueCard Program allows providers to conveniently submit claims for members from other state Blue Plans, including international Blue Plans, directly to Blue Shield of California. Blue Shield offers you a one-payor solution for submitting your BlueCard claims, and a point of contact for your claims-related questions, through the convenience of Blue Shield.

For more detailed information about the BlueCard Program, refer to Appendix 5-A of this manual or access the BlueCard Program web page at www.blueshieldca.com/en/provider/guidelines-resources/bluecard.

Other Payors

Blue Shield and its affiliates may contract with employers, insurance companies, associations, health plans, health and welfare trusts or organizations, other payors, and administrators (collectively, "Other Payors") to provide administrative services for plans provided by those entities which are not underwritten by Blue Shield. Such administrative services may include offering access to the physician and provider networks under contract to Blue Shield or its affiliates. In general, Other Payors must meet financial and administrative criteria established by Blue Shield, and their health programs must encourage the use of contracting providers. In the event that Blue Shield is not the underwriter of the health plan, the Other Payor shall be responsible for payment or covered services. The Other Payor Summary List is located on Provider Connection at www.blueshieldca.com/en/provider/guidelines-resources/policies-standards/other-payer-summary-list.

Blue Shield or its affiliates may adopt the policies and procedures of the Other Payors for services rendered for these members. Claims for Other Payors' members should be sent according to the *Where to Send Claims* link on Provider Connection at blueshieldca.com/provider or the member ID cards, which will generally identify where claims are to be submitted. Providers must look solely to the Other Payor for payment for covered services rendered to Other Payors' members (except for copays, coinsurance and deductibles which may be collected from members). Payments and allowances will be clearly shown on the Other Payors' *Explanation of Benefits* (EOBs).

Blue Shield Benefit Programs

Care Management

Blue Shield's comprehensive, integrated care management programs, including Shield Support, Shield Advocate, Shield Concierge, and Connect include member-focused clinical interventions to optimize health and quality of life. These programs offer a personalized, coordinated approach to care, encouraging members to be active participants in the management and improvement of their own health. Through shared decision making and a whole-person approach, the goal is for each member to receive care that is customized to their specific needs and preferences.

Blue Shield's experienced care management teams include registered nurses, licensed practical nurses, behavioral health clinicians, social workers, dietitians, physicians, and pharmacists who provide long and short-term support, including:

- **Case management** for acute, long-term, and high-risk conditions, designed to help members live better with illness, recover from acute conditions, and develop self-management skills
- **Care coordination** services to help members navigate the healthcare system and access care, and to facilitate information sharing among the healthcare team involved in the member's care

Through skilled interviewing, the care team empowers members to take action and choose their own health goals. A personalized care plan is developed to help ensure that member' needs and preferences are known and communicated. The care team maintains frequent contact with members, their caregivers, and providers in order to help assure the provision of safe, appropriate, and effective care and provides support by coordinating the wide range of specialized care from numerous providers to help prevent duplicate or unnecessary treatments and tests. The care team also provides coaching on medical conditions as well as behavioral health support and lifestyle modifications for an optimal quality of life.

Blue Shield's care team works to prevent readmissions by completing safety risk assessments, discussing follow-up care plans, reconciling medication, and facilitating adherence to prescribed treatment plans. The care team prepares members in advance for hospital stays, including guided imagery recordings to assist members in preparing for surgery or dealing with other health issues. These programs are supported by medical directors who provide clinical direction and oversight to the care team.

Blue Shield's care management programs are designed to allow the member to better manage their medical treatment, their health condition, and the many related issues that may impact their quality of life.

Care Management *(cont'd.)*

Member identification for Blue Shield's care management programs is based on a customized predictive risk score. This predictive risk score was developed to optimize outreach to those members who are likely to become high risk and are most likely to benefit from care management support. Additionally, condition specific triggers and utilization patterns are used to identify members.

Members may also be identified from an acute event or hospital admission or discharge. Care management encompasses a broad spectrum of interventions that provide support for short-term care coordination as well as ongoing complex case management for the following conditions or utilization (including but not limited to):

- Behavioral health
- Cancer
- Cardiovascular, e.g., Coronary Artery Disease, Heart Failure
- Catastrophic injury
- Diabetes
- Musculoskeletal
- Chronic Pain
- Respiratory, e.g., Asthma, COPD
- End-stage renal disease
- Stroke
- Transgender
- Transplant (solid organ and bone marrow)
- Pre-term infants in the Neonatal Intensive Care Unit (NICU) and post NICU
- Plus: ER utilization, post-discharge from hospital, opioid use, high cost and direct referrals

The following services are offered through the care management programs:

- Telephonic coaching from nurses, behavioral health clinicians, social workers, and pharmacists
- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- Cognitive behavioral therapy modules
- Online tools and educational materials

Care Management *(cont'd.)*

Maternity Management

Blue Shield has teamed up with Maven to offer Maven Maternity to our members at no cost. Maven Maternity is a 24/7 digital and virtual program designed to support Blue Shield members during and after pregnancy. Maven is also available to eligible Blue Shield medical plan members and their partners who have experienced a pregnancy loss. Blue Shield members can use Maven to book coaching and educational video appointments with providers across more than 30 specialties, including OB-GYNs, mental health specialists, doulas, lactation consultants, and more at no cost. Providers can encourage members to enroll in the Maven Maternity Program by visiting www.blueshieldca.com/maternity.

Screening, treatment, and referral to services for maternal mental health-related conditions is strongly encouraged. If a member screens positive for a mental health condition, such as anxiety or depression, Blue Shield physicians can refer directly to a behavioral health provider. Physician referrals are an important component of Blue Shield's Care Management Programs and may allow for identification of a member more quickly. Blue Shield providers may connect a member to appropriate maternal mental health resources through accessing multiple pathways based on member's needs. These include connecting directly to Maven, through Blue Shield Care Management, behavioral health providers through the Mental Health Service Administrator, Magellan network, or behavioral health providers through the Blue Shield of California Provider Network.

Providers can refer to Blue Shield Care Management Programs by submitting the referral form via secure email to bscliaison@optum.com or fax to (877) 280-0179. To download an electronic copy of the referral form, please visit www.blueshieldca.com/provider/guidelines-resources/patient-care/programs.sp. Providers can refer members to Magellan by calling Customer Service at (877)263-9952 or request a clinical referral form at BSCClinicalLiaison@MagellanHealth.com. Each referral will be evaluated for eligibility and appropriateness.

Care Management *(cont'd.)*

Additional Care Management Program Descriptions

The following programs are available to certain Blue Shield members depending on their plan design:

- **Shield Advocate.** The Shield Advocate program provides a designated team of registered nurses to a client's membership to provide a proactive, member-focused approach to navigate the healthcare system, resolve problems, answer health and treatment related questions, provide health counseling, and support coordination of care.
- **Shield Concierge.** Shield Concierge is an integrated service designed to provide a customer-specific, personalized service experience for members covered by Blue Shield. This program strives to improve and expand the member experience by resolving more inquiries during the first contact with the member and proactively identifying services specifically beneficial to the member. A team of professionals consisting of Shield Concierge representatives, registered nurses, social workers, health coaches, pharmacy technicians and pharmacists provide information to a member regarding benefits, doctors and specialists, coordination of care, case management, and questions on formulary and drug authorizations.
- **Connect.** Connect offers an integrated, holistic, and personalized healthcare experience based on each member's needs, including a broad spectrum of robust, member-focused interventions driven by a smart-data platform with predictive analytics that leverage our best-in-class member care teams. The Connect care team is composed of specialists across claims and benefits, clinicians and care managers, pharmacists and technicians, and social workers to address any questions that could be asked during the first call. In those rare instances in which additional information is needed and a call cannot be resolved, the Connect care team takes complete ownership of any remaining tasks and offers to call the member back once resolved. The Connect care team proactively engages members, either digitally or over the phone, when early interventions or extra communications might lead to better health outcomes. Members are guided to available programs and resources to address their health issues, prevent emergency-room visits, and avoid higher costs associated with inpatient admissions in the future.
- **Home-Based Complex Care.** Chronically ill members meeting certain criteria are offered 24/7 access to medical professionals and in-home urgent care. Community-based, physician-led medical teams specializing in house calls and home-based care deliver medically needed services to these chronically ill members with complex needs. The program offers access to nurse practitioners, registered nurses, care managers, social workers, health coaches, pharmacists and more. Visits may be delivered in-person, by phone or video. This does not replace members' primary care providers but rather supports the work of these members' existing providers. The program clinicians communicate and collaborate with the members' PCPs and specialists to reinforce the PCP's in-office care plan. Blue Shield identifies eligible members for this program based on their health status and needs.

Wellness and Prevention Programs

Blue Shield offers member-directed health improvement programs. Our mission is to support a member's access to high quality care and facilitate participation in managing his or her own health. Blue Shield actively encourages providers to become familiar with these programs so they can assist members in learning about and taking advantage of these services. Blue Shield offers the following preventive health and wellness initiatives:

Diabetes Prevention Programs

The Diabetes Prevention Programs helps members who are at risk of type 2 diabetes lose weight and adopt healthy habits. During the six months program members will learn new ways to eat healthier, increase activity, and manage challenges with help from a personal health coach and a small support group. The programs embedded in the Wellvolution platform can be accessed by enrolling in Wellvolution at www.wellvolution.com.

LifeReferrals 24/7℠

A phone call connects members with a team of advisers who can help them with personal, family, and work issues. They will be guided to the appropriate professional, depending on their needs. Some of the services offered are:

- **Legal and financial –** Members can connect with a financial coach on money matters or an attorney on a variety of legal services. Members may be eligible to receive a 60-minute legal consult and two 30-minute financial consults at no cost to them.
- **Personal challenges including relationship problems or coping with grief –** Members receive 3 telephonic or face to face sessions with a licensed therapist in any six-month period at no cost to them.
- **Work/life resources –** Members can consult with a specialist who can provide useful information and referrals to a wide range of resources, such as educational programs, adult and elder care, childcare, parenting resources, meal programs, relocation services, transportation, and more.

The LifeReferrals 24/7 team is available to discuss your patients' concerns and guide them to possible solutions anytime, day or night, at (800) 985-2405. All of the services and referrals to resources are treated confidentially.

Wellness and Prevention Programs *(cont'd.)*

NurseHelp 24/7SM

Members can access a registered nurse anytime, day or night, seven days a week, 365 days a year at no cost by phone at (877) 304-0504 or online at www.blueshieldca.com/nursehelp. Experienced nurses are ready to answer questions, listen, and provide members with information that can help them choose the most appropriate level of care for their situation. The nurses are trained to offer callers:

- **Health information** - Better understanding of health concerns and chronic conditions, education about possible treatment options to help patients make informed decisions and suggestions for preparing for doctor appointments.
- **Healthcare assistance** - Guidance in understanding and choosing the most appropriate types of health care such as hospital, urgent care center, doctor visit, or home treatment. Assistance with questions about medical tests, medications and living with chronic conditions.
- **Preventive and self-care measures** - Helpful tips for taking care of minor injuries at home, such as a twisted ankle or a common illness like a cold or the flu.
- **Online nurse help** - One-on-one personal Internet dialogue with a registered nurse 24 hours a day, seven days a week. Members get immediate answers to their general health questions and research assistance. The online nurses can also refer members to health information, resources, and member programs on blueshieldca.com.

LifeReferrals 24/7 and NurseHelp 24/7 are designed to complement, not replace, the care you provide to your patients.

Preventive Health Guidelines

Blue Shield's Preventive Health Guidelines are based on nationally recommended guidelines for screening examinations, immunizations, and counseling topics for healthy individuals, as well as for individuals at risk for disease. These guidelines are updated and distributed annually to members via blueshieldca.com. Clinical reference sources may include the US Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services, American Academy of Pediatrics, the Advisory Committee on Immunization Practice, and the Health Resources and Services Administration Women's Preventive Services Guidelines.

Guidelines available in both English and Spanish are located on Provider Connection at www.blueshieldca.com/en/provider/guidelines-resources/patient-care-resources/preventive-health.

Wellness and Prevention Programs *(cont'd.)*

Preventive Health Services Policy

Blue Shield has developed a Preventive Health Services Policy as a result of the Affordable Care Act (ACA) of the health reform legislation, adopting United States (US) Preventive Services Task Force (USPSTF) recommendations; the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) recommendations for infants, children, adolescents, and women; immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC); American Academy of Pediatrics/Bright Futures/Recommendations for Pediatric Preventive Healthcare; and additional requirements mandated by the state of California. This policy applies to new and renewing members.

These services, when criteria are met and the primary reason for the visit is preventive care, will be provided under the preventive care services benefits with no cost-sharing to the member when applicable procedure and diagnosis codes are billed together. When a preventive service is provided during a non-preventive visit, the entire visit will be provided under the medical benefit of the member's plan, and cost-sharing may apply per member benefits.

The Preventive Health Service Policy is available on Provider Connection at www.blueshieldca.com/en/provider/guidelines-resources/patient-care-resources/preventive-health.

Wellness Discount Programs

To make it easier for members to take care of themselves, Blue Shield offers a wide range of member discounts on popular programs that can help them save money while they get healthier, including:

- **Fitness Your Way by Tivity** –With 4 different gym packages to choose from, including a digital only package, members have access to thousands of well-known fitness locations near home, work, or when traveling nationwide all for a low one time initiation fee and a low monthly cost. Simply visit www.fitnessyourway.tivityhealth.com/bsc to enroll.
- **Alternative Care Discounts** – 25% off on acupuncture, chiropractic services, and therapeutic massage services from practitioners participating in the ChooseHealthy® program.
- **Discount Vision Program** – Discounts on vision exams, frames and lenses, contacts lenses, and more.
- **LASIK surgery** – Discounts on LASIK surgery through QualSight LASIK, and LASIK and PRK surgery through NVISION, Inc.

Wellness and Prevention Programs *(cont'd.)*

Wellvolution

Wellvolution focuses on things that make our members happier and healthier. The platform offers digital and in-person whole health programs designed to give our members a way to go beyond just doctors and prescriptions and live their best life. There are over 10 programs to choose from, ranging from general well-being, to supporting stress, sleep, and other mental health concerns, to helping members prevent or treat and reverse the course of serious chronic conditions. With the right tools, coaching, nutrition counseling and health professional support, members can succeed with small changes today to make a big difference for a healthier tomorrow. Once the member receives their Blue Shield member ID card, they can go to www.wellvolution.com to set up their profile, preferences and pick programs. Wellvolution customizes the path to better health, matching the member with programs and popular apps that are personalized and have proven results, at no extra cost.

The following programs are offered through Wellvolution and are 100% covered by Blue Shield:

- **Well-Being Programs –** A hand-selected set of proven general well-being programs, designed to help generally healthy members achieve their health goals of sleeping better, lowering stress, exercising more, eating better or quitting smoking.
- **Mental Health Programs** – To support our members in achieving optimal whole person health, our mental health programs are perfect for members that are seeking opportunities to incorporate everyday mindfulness into their daily lives to reduce stress, increase resilience, and get a better night's rest as well as for members seeking support for low- to moderate- anxiety or depression. Programs include guided meditations, sleepcasts, mindfulness exercises, 24/7 Behavioral Health coaching, personalized care plan, and more.
- **Weight Loss Programs –** Programs specifically designed to help you make changes that fit your lifestyle and promote a healthy weight. You can lose weight and keep it off with coaching support and a personalized step by step plan on how to decrease cravings, hunger and weight without dieting. Most members see an average loss of 3-4 pounds per week and improvement in their quality of life across the board.
- **Disease Prevention Programs** – Targeting reduction of risk for type 2 diabetes and heart disease, prevention programs provide you with a health coach and an individualized plan that meet your unique needs and address several areas of your life, including physical activity, nutrition, sleep, and stress management. Most members see a reduction in medications they take, as well as normalization of blood sugar and blood pressure.

Wellness and Prevention Programs *(cont'd.)*

Wellvolution *(cont'd.)*

- **Chronic Condition Reversal Programs** – Turn back the clock and reverse the course of chronic conditions like hypertension, musculoskeletal health, type 2 diabetes and more with the support from physician, health coaches and a supportive patient community. Our high touch reversal programs, often incorporating in-person or digital coaching options, are focused on normalization of A1C levels, weight, and blood pressure, as well as elimination of medication dependence in a matter of weeks.

Section 6: Capitated Hospital Requirements

This page intentionally left blank.

Table of Contents

This page intentionally left blank.

Section 6: Capitated Hospital Requirements

Overview

The following information applies only to hospitals with Blue Shield capitated payment arrangements.

In addition to the responsibilities described in Section 2: Hospital and Facility Responsibilities, capitated hospitals must also adhere to the requirements outlined in this section.

Capitated hospitals have Blue Shield contracts under which they are paid on a per member or percentage of revenue basis to provide, or assure provision of, an identified spectrum of services to eligible HMO members. When hospitalization is needed, the member is required to secure services from the capitated hospital to which they are assigned.

For assigned HMO members, capitated hospitals or facilities are obligated to provide, or to arrange for the provision of and payment for all medically necessary services specified in the Capitated Hospital Agreement. These services usually include, but are not limited to:

- Inpatient hospital services
- Facility services for facility-based (hospital or ambulatory surgery center) outpatient surgeries/procedures
- Skilled nursing facility (SNF) services
- Home health agency/hospice services
- Ambulance services
- Durable medical equipment (DME)
- Emergency services, as specifically defined in the hospital's Blue Shield Agreement

Monthly Eligibility Reports

As a cost-effective measure, Blue Shield provides the Combined Eligibility/Capitation Report and the Eligibility Adds and Termination Report only in electronic format. Receiving eligibility information electronically enables capitated hospitals to use and sort the information in many ways to meet their specific reporting needs.

The monthly Combined Eligibility/Capitation Report shows capitation details for all capitated hospitals for a specific reporting period. It includes the calculated payment amounts for all currently-eligible capitated members. This file is the supporting documentation for the Monthly Capitation Reconciliation Report for the HMO and POS products. For Blue Shield Medicare Advantage, the Combined Eligibility/Capitation Report is the supporting documentation for the hospital's wire transfer payment.

Blue Shield distributes these eligibility reports via Blue Shield secure email, or via SFTP to all capitated hospitals for the Blue Shield Medicare Advantage HMO and PPO plans (Individual and Group-MAPD), HMO, and Point-of-Service (POS) products. For details on the file formats, refer to Appendix 6-A and 6-B in the back of this manual.

Both reports include the member's name and identification number as well as the activity code for all member status changes. The files also include the member's group number and Product ID. The Product IDs are codes that identify the member's standard office visit copayments. Product IDs and Physician Office Copayment Guides for commercial HMO plans and for the Blue Shield Medicare Advantage HMO and PPO (Individual and Group MAPD) plans are forwarded each month along with the Combined Eligibility/Capitation Reports.

Capitation

For Commercial HMO and POS members, Blue Shield will be financially responsible for all covered services provided by a capitated hospital to an ineligible person or a retroactively cancelled member for the period of time for which capitation was retroactively adjusted and who had been previously verified as eligible by Blue Shield, as long as the capitated hospital has:

- Provided documentation to Blue Shield of the eligibility error, along with the claim for services.
- Provided documentation that payment was made by the capitated hospital to the provider of service, if applicable. Documentation should include:
  - Member name
  - Member ID number
  - Place, date, and provider of service
  - A claim showing the services provided and the billed/paid amount

If the member is determined to be ineligible or retroactively cancelled, Blue Shield will reimburse the capitated hospital using the payment methodology described in the Blue Shield contract.

Capitated Services Claims Processing

Commercial

A capitated hospital is delegated the responsibility for timely and accurate processing/ payment of all capitated service claims to its providers.

Section 1371 of the Knox-Keene Act requires health care service plans and their subcontracted hospitals to reimburse all claims, professional or institutional, within 45 working days after receipt of the claim unless the claim or portion thereof is contested. If contested, the health plan or their contracted hospital must notify their claimant in writing within 45 working days as to why the claim was contested. If the uncontested claim or contested claim (after the receipt of necessary information) is not paid within the specified time period, interest shall accrue at the rate of 15% per annum for all non-emergency care, or the greater of $15.00 for each 12-month period or portion thereof or 15% per annum for emergency care beginning with the first calendar day after the 45 working day period.

All interest due should be automatically included with the claim payment. Interest must be issued within five working days of the payment of the claim without the need for any reminder or request by the provider. If the interest is less than $2.00 at the time that the claim is paid, the health plan or the plan's capitated provider may pay the interest on that claim along with interest on other such claims within 10 calendar days of the close of the calendar month in which the claim was paid as long as a statement identifying the specific claims for which the interest was paid is included. If interest is not paid "automatically," the required interest and a $10.00 penalty would be warranted. Delegation continues as long as processing and payment remain compliant with statutory, regulatory, and Blue Shield standards.

Medicare Advantage/Group Medicare Advantage

A capitated hospital is delegated the responsibility for timely and accurate processing/payment of all capitated service claims to its providers. Hospitals are required to reimburse all clean unaffiliated claims, professional or institutional, within 30 calendar days after receipt of the earliest received date of the claim. If the unaffiliated clean claim is not paid within the specified time period, interest shall accrue, if applicable, at the applicable current prompt payment rate. Interest payments are only applicable to out-of-network providers. All interest due should be automatically included with the claim payment. Hospitals are required to reimburse all affiliated and unclean unaffiliated claims, professional or institutional, within 60 calendar days after receipt of the earliest received date of the claim. If unclean, the health plan or their contracted hospital must develop the claim for the missing information from their claimant. Payment/denial must be made on all unclean claims within 60 calendar days.

Capitated Services Claims Processing *(cont'd.)*

Incorrect Claims Submissions

Incorrect claims submissions, also known as misdirected claims, are claims for capitated services that providers erroneously submit to Blue Shield for processing/payment instead of submitting appropriate claims or encounter reports to the capitated hospital.

Commercial

In accordance with Section 1300.71, California Code of Regulations (CCR) Title 28, Blue Shield must forward non-contracted provider service claims and/or emergency service claims that are the responsibility of the capitated hospital to the correct hospital within ten (10) working days of the original receipt date. For all other capitated hospital claims in which the provider is contracted with the hospital and that are the responsibility of the capitated hospital, Blue Shield may either send the claimant a notice of denial, with instructions to bill the capitated provider or forward the claim to the appropriate capitated provider. Blue Shield has developed a process to allow us to forward applicable claim information, for paper- and electronically-submitted claims, to the appropriate capitated hospital in the form of a facsimile. Facsimiles forwarded to the capitated hospital must be treated as a claim. If additional information is required to make the determination to pay or deny, the capitated hospital may either develop or contest the claims for the missing information. Claims may only be contested if information is missing that is necessary to process the claim. Claims cannot be contested solely because the claim is submitted on a UB-04 or CMS 1500 facsimile claim form. If a claim that is payable by Blue Shield is submitted to the capitated hospital in error, the capitated hospital must forward the claim to Blue Shield within 10 working days.

Medicare Advantage/Group Medicare Advantage

Any claim misdirected must be forwarded to the appropriate payor. The claim processing cycle begins with the received date of the forwarding entity (earliest received date). Health plans should forward claims within ten (10) working days of the original receipt date.

If the delegated hospital is receiving a significant number of claims that are forwarded late by any entity and the volume of those late claims is enough to impair the delegated hospital's timeliness performance, Blue Shield Medicare Advantage plan will work with the entity forwarding the late claims. Documentation should be sent to your Provider Claims Compliance Auditor for support.

Capitated Services Claims Processing *(cont'd.)*

Paper Submissions

For compliance review, submission of claim information for denied services is not required for routine review purposes unless the hospital has been directed to do so by a Blue Shield auditor or the service falls into classifications that Blue Shield's Medical Care Solutions staff requires 100% submission. For more details, please refer to Section 3: Medical Care Solutions of this manual. For encounter data submission, if the hospital submits its encounter data on paper, denied claims should be marked as such and included with those encounter claim documents for reporting purposes only.

Electronic Submissions

Claim information for denied services *must not* be included in the capitated hospital's approved monthly encounter reports, since Blue Shield is unable to identify them in the electronic format and thus cannot record them correctly for reporting purposes. Denied claim information should be sent on paper or in pre-approved report format to the address listed in the next section for all encounter submissions, along with the reason for denial.

Encounter Data Submission

Blue Shield Organization and Procedures

Capitated hospitals are required to submit all encounter data to Blue Shield for Access+ HMO and Blue Shield Medicare Advantage plan members. This includes encounters for inpatient, outpatient, and other facility-based services for which they are capitated. This also includes information on purchased services and any downstream sub-contracted services.

Denied encounters must also be sent to Blue Shield. In addition to all allowable inpatient and hospital outpatient encounter data, denied encounter information must be forwarded by Blue Shield Medicare Advantage plan to the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage members.

For both commercial and Medicare encounter data, submissions may be made directly to Blue Shield or via a vendor. Regardless of the route of submission, providers may request further information on facility encounter data specifications and procedures from Blue Shield at one of the contacts listed below. Encounter data must be submitted in HIPAA compliant ANSI 837P and 837I formats.

Encounter Data Submission *(cont'd.)*

Commercial and Medicare Encounter Data

For EDI questions, contact the EDI Help Desk (800) 480-1221. For encounter processing questions, call the Customer Service number on back of the member's card.

A list of approved vendors can be found on Provider Connection at www.blueshieldca.com/provider. Click on *Claims*, *Manage Electronic Transactions*, then *How to enroll in EDI*.

Performance – Regular and Complete Submission of Encounter Data

Monthly Submission

Blue Shield requires encounter data be submitted at least once each month and each submission must be in the correct HIPAA-compliant electronic format with usable data. Files with significant data quality problems may be rejected and require correction of problems.

Complete Submission

Blue Shield measures encounter submissions on a rolling 12 months of utilization. For Medicare Advantage encounter data submissions to the federal government (CMS), there is also a compliance measurement reflecting the data collection period. The Medicare benchmark is modified periodically to reflect changes in CMS' expectations for Medicare encounter data. Contact the appropriate Blue Shield unit to inquire about specific benchmarks.

Blue Shield requires that, on a periodic basis, an officer of the capitated facility attest to the completeness and truthfulness of encounter data submission.

Confidentiality of Substance Use Disorder Patient Records

In 1975, Congress enacted 42 U.S.C. 290dd-2 and its supporting regulations at 42 C.F.R. Part 2. The law is formally referred to as the Confidentiality of Substance Use Disorder Patient Records Act, and informally referred to as "Part 2." The purpose of Part 2 is to protect the privacy of substance use disorder (SUD) patient records by prohibiting unauthorized use and disclosure of SUD patient records except with patient consent and in limited circumstances.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that regulates and enforces Part 2.

If, as a provider, you are a Part 2 Program, you must comply with all of the applicable legal requirements of the Part 2 laws and regulations.

To assist you in meeting your legal obligations, you may inform Blue Shield that you have the patient's consent to disclose their SUD patient records to Blue Shield when submitting an electronic claim (837 P or I) for Part 2 services by placing an "1" in the CLM09 field.

When submitting an electronic claim (837 P or I) for Part 2 services, under the NTE02 segment, you may include in the free-form narrative one of the following mandatory Part 2 disclaimer language options. The shorter version is preferable.

- 42 CFR part 2 prohibits unauthorized disclosure of these records; or
- This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

To help you determine if you are a Part 2 Program, please refer to:
www.samhsa.gov/sites/default/files/does-part2-apply.pdf.

To learn more about the Part 2 laws and regulations, please refer to:
www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-patient-records.

To learn more about how Part 2 limits the disclosure of SUD patient records, please refer to:
www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf.

It is recommended that you consult legal counsel if you are uncertain whether or how these provisions apply to you.

Table of Contents

Appendix for Section 1

This page intentionally left blank.

Access+ Provider Group
A medical group or IPA that participates in the Access+ HMO program. The features of the Access+ Program include Access+ *Satisfaction* and Access+ *Specialist*.

Access+ Satisfaction®
A feature of the Access+ HMO program that allows HMO members to provide feedback regarding services received from HMO network physicians and their office staff.

Access+ *Specialist*℠
A feature of the Access+ HMO program that allows HMO members to self-refer, for an increased copayment, to a specialist within their IPA/medical group for Access+ *Specialist* services without a referral from their primary care physician.

Access+ *Specialist* Services
Services covered under the Access+ *Specialist* option of the Access+ HMO Program.

Activities of Daily Living
Mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

Acute Care
Care rendered while treating an illness, injury or condition that is marked by a sudden onset or abrupt change of status requiring prompt attention. It may include hospitalization, but of limited duration and not expected to last indefinitely. Acute care is in contrast to chronic care. See *Chronic Care*.

Advance Directives
Documents signed by a member that explain the member's wishes concerning a given course of medical care should a situation arise where he/she is unable to make these wishes known. Advance directives must be documented in a prominent place in the medical record for all Blue Shield members 18 years and older.

Affordable Care Act
The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Allowed Amount
The adjudicated claim cost for covered benefits at the contracted rate, including the member's copayment/co-insurance portion.

Glossary

Alternate Care Services Provider
Home health care agencies, pharmacy home infusion suppliers, home infusion suppliers and home medical equipment suppliers.

Ambulatory Surgery Center (ASC)
Any ambulatory surgical center that is certified to participate in the Medicare program under Title XVII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4. It is also known as a "surgicenter."

Appeal, Member
A request for Blue Shield's or Blue Shield's Life's reconsideration of an initial determination (either verbal or written) which resulted in the following:

- Complete denial of service, benefit, or claim
- Reduction of benefits or claim payment
- Redirection of service or benefits
- Delay of prospective authorization for service or benefits
- Underwriting Investigation Unit (UIU) cancellation of coverage or enrollee underwriting denials

Appeal, Provider
A written statement from a provider disputing the decision to reduce, delay, or deny services or benefits, requesting the original decision is altered or overturned.

ASP
ASP refers to the Average Sales Price is a market based price that reflects the weighted average of all manufacturer sales prices that includes all manner of discounts. The ASP is issued by CMS quarterly based on the information submitted by the manufacturer and is a reference point to estimate acquisition costs.

AuthAccel
A tool that allows providers to submit authorization requests to Blue Shield online, via Provider Connection, instead of calling or faxing to obtain authorization. This tool may only be used to request authorizations for services where Blue Shield is responsible for providing authorization. Requesting providers may use AuthAccel to complete, attach documentation, submit, track, 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. When providers submit requests for pharmacy authorizations 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.

Authorization
A process required for certain services in order to be reimbursed (e.g., approval to receive care from a provider other than the member's primary care physician). There are two types: pre-certifications or utilization reviews (URs). All non-capitated services require one or the other. Inpatient facility claims, and outpatient surgeries require an UR. Ambulance, home medical equipment, and home health care require pre-certification. Authorizations are performed by the Medical Operations team at each core site.

AWP
AWP refers to the Average Wholesale Price of pharmaceuticals dispensed per NDC Code as set forth in a nationally recognized pricing source such as First Data Bank and its supplements or other such sources, as determined by Blue Shield.

Balanced Budget Act of 1997 (BBA)
Legislation signed into law by President Clinton in August 1997. This legislation enacts the most significant changes to the Medicare program since its inception 30 years ago.

Benefits
Covered health care services pursuant to the terms of the member's health services contract.

Benefit Period (Blue Shield Medicare Advantage Plan)
A way of measuring the use of services under Medicare Part A. A benefit period begins on the first day of a Medicare-covered inpatient hospital stay and ends when a member has been out of the hospital (or other facility that primarily provides skilled nursing or rehabilitative services) for 60 consecutive days, including the day of discharge.

Biosimilar
A Federal Drug Administration (FDA) approved biological product that is highly similar in structure and function to an existing biologic. Biosimilars have been tested to demonstrate no clinically meaningful differences in safety and efficacy from the original product.

BlueCard Access®
A toll-free number – **(800) 810-BLUE** – for you and members to use to locate healthcare providers in another Blue plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

BlueCard *Eligibility*®
A toll-free number – **(800) 676-BLUE** – for you to verify eligibility, benefits coverage, share of cost information, and prior authorizations on patients from out-of-state Blue plans.

Glossary

BlueCard National Doctor and Hospital Finder
www.bcbs.com/find-a-doctor
A website you can use to locate healthcare providers in another Blue Cross and/or Blue Shield plan's area. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you as a provider is incorrect on the website, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091.

BlueCard PPO
A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard PPO Basic
A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield plan's service area the PPO basic level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO Basic provider. When you see the "PPOB" in a suitcase logo on the front of the member's Blue plan ID card, it means the member has selected a PPO plan product from a Blue Cross Blue Shield plan. Since Blue Shield of California does not have a BlueCard PPO Basic network, providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California.

BlueCard PPO Member
A Blue plan patient who carries an ID card with a suitcase symbol containing "PPO" in it. Only members with this identifier can access the benefits of the BlueCard PPO.

BlueCard PPO Network
The network comprising those physicians, hospitals and other healthcare providers PPO members may elect to use to obtain the highest level of PPO benefits.

BlueCard PPO Provider
A doctor, hospital or other healthcare entity enrolled in a network of designated PPO providers.

BlueCard Routing Logic
A streamlined IT solution that Blue Shield of California developed that integrates with a provider's clearinghouse and/or eligibility and benefits verification vendor's system to simplify and automate selecting the correct California Blue plan for processing BlueCard claims. The BlueCard routing logic is an alternative to using our Claims Routing Tool on the Blue Shield Provider Connection website.

BlueCard Traditional
A national program that offers members traveling or living outside of their Blue plan's service area the traditional, or indemnity, level of benefits when they obtain services from a physician or hospital outside of their Blue plan's service area. These members will carry an ID card featuring an "empty" suitcase logo.

Blue Shield Medicare Advantage Plans
Blue Shield's Medicare Advantage plans include all plans under contracts H0504 (HMO), H2819 (HMO DSNP), H4937 (PPO), H5928 (HMO). The terms "Medicare Advantage" and "MA-PD" may be used interchangeably throughout this manual.

Blue Shield Medicare Advantage Plan Member
An individual who meets each of the applicable eligibility requirements for membership, has voluntarily elected to enroll in Blue Shield Medicare Advantage HMO or PPO plan, has paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield Medicare Advantage HMO or PPO plan has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Blue Shield Medicare Advantage Plan HMO Network
A group of physicians, hospitals, and other healthcare providers that contracts with Blue Shield to provide medical and facility-based care to Blue Shield Medicare Advantage HMO plan members. When the member selects a Primary Care Physician (PCP), he or she is also choosing the hospital and specialty network associated with his/her PCP. This is different than the Access + HMO network.

Blue Shield Global Core®
A program that allows Blue plan members traveling or living abroad to receive nearly cashless access to covered inpatient hospital care, as well as access to outpatient hospital care and professional services from healthcare providers worldwide. The program also allows members of international Blue Cross and/or Blue Shield plans to access domestic (U.S.) Blue provider networks.

Blue Web
Blue Cross and Blue Shield Association's website at blueweb.bcbs.com which contains useful information for providers.

California Children's Services (CCS)
California Children's Services (CCS), formally known as the Crippled Children's Services, was introduced by the California Legislature in 1927. This program was developed to provide medical treatment and rehabilitation to children who suffer from catastrophic medical conditions. CCS is funded through county, state, and federal tax dollars, as well as through some fees paid by the families receiving care. CCS is not a Medi-Cal or Medicare program.

Glossary

Capitation
A prepaid monthly fee paid to the IPA/medical group for each Blue Shield member in exchange for the provision of comprehensive health care services.

Case Rate
The all-inclusive rate paid, in accordance with the hospital contract Exhibit C, for specified types of care that are paid regardless of the type or defined duration of services provided by the hospital. For specified care/diagnoses, Blue Shield pays the stated Case Rate in lieu of the Per Diem rate.

Centers for Medicare & Medicaid Services (CMS)
An agency within the U.S. Department of Health and Human Services which administers the Medicare Program and with whom Blue Shield has entered into a contract to provide healthcare and Medicare prescription drug coverage to Medicare beneficiaries.

Chronic Care
Care (different from acute care) furnished to treat an illness, injury, or condition, which does not require hospitalization (although confinement in a lesser facility might be appropriate), that may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by a recurrence requiring continuous or periodic care, as necessary. See *Acute care*.

COBRA
Consolidated Omnibus Budget Reconciliation Act. It provides for the continuation of group health benefits for certain employees and their dependents (applies to groups of 20 or more employees). A member may elect to continue coverage under COBRA if coverage would continue as a result of a "qualifying event". (A qualifying event may be termination of employment or reduction of hours, etc.)

Coinsurance
The percentage amount that a member is required to pay for covered services after meeting any applicable Deductible. Specific coinsurance information is provided in the members' *Summary of Benefits*.

Coinsurance (Blue Shield Medicare Advantage HMO and PPO Plans)
The percentage of the Blue Shield Medicare Advantage HMO and PPO plans contracted payment rate or Medicare payment rate that a member must pay for certain services.

Commercial Plans or Programs
All plans other than Medicare Advantage plans, including, but not limited to, Blue Shield Preferred Plans, Access+ HMO® group benefit plans, Access+ HMO Plan for Individuals and Families, HMO POS plans, BlueCard, and government-sponsored programs (i.e., Healthy Families and Major Risk Medical Insurance).

Consumer Directed Healthcare/Health Plans (CDHC/CDHP)
Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. CDHC plans provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information and financial incentives.

Contracted Provider
A credentialed health care professional or facility that has a contract with Blue Shield to provide services to members.

Contract Year (Blue Shield Medicare Advantage HMO and PPO Plans)
The contract year for Medicare beneficiaries begins on January 1st and continues for a 12-month period. *Note*: The contract year for Group MA-PD members could begin at varying times of the year (for example July 1st or October 1st) and continues for a 12-month period.

Coordination of Benefits (COB)
A term used to describe a process to determine carrier responsibility when a member is covered by two or more group health plans. One of the carriers is considered the primary carrier and its benefits are paid first. Any balance is then processed by the secondary carrier, up to the limit of its contractual liability.

Copayment
The fixed dollar amount that a member is required to pay for covered services after meeting any applicable deductible. Specific copayment information is provided in the members' *Evidence of Coverage* or *Summary of Benefits*.

Cosmetic Procedure
Any surgery, service, drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic within the broad range of normal, but which is considered unpleasing or unsightly.

Covered Services
Those services provided to a member pursuant to the terms of a group or individual health services contract and noted in the member's *Evidence of Coverage*. Medically necessary health care services, which a member is entitled to receive pursuant to the *Health Services Contract* and *Evidence of Coverage* applicable to the member. Except as otherwise noted in the member's *Health Services Contract* and *Evidence of Coverage*, covered services must generally be referred to and authorized in conformity with Blue Shield's Utilization Management programs.

Glossary

Credentialing
The process in which Blue Shield verifies the evidence of a physician's education, residency training, clinical capabilities, licenses, references, board certification, state and federal disciplinary sanctions and other components of the physician's professional abilities and history.

Custodial Care
Care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self-care and/or supervisory care by a physician); or care furnished to a member who is mentally or physically disabled, and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or when despite such treatment, there is no reasonably likelihood that the disability will be so reduced.

Delegation
The process by which Blue Shield allows the IPA/medical group to perform certain functions that are considered the responsibility of Blue Shield for the purpose of providing appropriate and timely care for Blue Shield members.

Dependent (Commercial Only)
A dependent is an individual who is enrolled and maintains coverage in the Plan, and who are defined as:

1. A subscriber's legally married spouse who is:
   a. Not covered for benefits as a subscriber; and
   b. Not legally separated from the subscriber; or,
2. A subscriber's domestic partner who is not covered for benefits as a subscriber; or,
3. A child of, adopted by, or in legal guardianship of the subscriber, spouse, or domestic partner. This category includes any stepchild or child placed for adoption or any other child for whom the subscriber, spouse, or domestic partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for benefits as a subscriber, is less than 26 years of age, has been enrolled and accepted by Blue Shield of California as a dependent, and has maintained membership in accordance with the contract.

Note: Children of dependent children (i.e., grandchildren of the subscriber, spouse, or domestic partner) are not dependents unless the subscriber, spouse, or domestic partner has adopted or is the legal guardian of the grandchild.

Dependent (Commercial Only) *(cont'd.)*

4. If coverage for a dependent child would be terminated because of the attainment of age 26, and the dependent child is disabled, benefits for such dependent will be continued upon the following conditions:
   a. The child must be chiefly dependent upon the subscriber, spouse, or domestic partner for support and maintenance;
   b. The subscriber, spouse, or domestic partner submits to Blue Shield a Physician's written certification of disability within 60 days from the date of the employer's or Blue Shield's request; and
   c. Thereafter, certification of continuing disability and dependency from a physician is submitted to Blue Shield on the following schedule:
      i. Within 24 months after the month when the dependent would otherwise have been terminated; and
      ii. Annually thereafter on the same month when certification was made in accordance with item 4 (a) above. In no event will coverage be continued beyond the date when the dependent child becomes ineligible for coverage under this plan for any reason other than attained age.
5. AB 570 requires an individual health plan/policy that provides dependent coverage to make dependent coverage available to a parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the health care service plan's service area.
   a. The bill redefines "dependent" under both the Health and Safety Code and the Insurance Code to include the "parent or stepparent" of an individual, subject to applicable terms of the health benefit plan.
   b. Under Section 152(d) of Title 26 of the United States Code, the term "qualifying relative" means, with respect to any taxpayer for any taxable year, an individual:
      i. who bears a relationship to the taxpayer described in the statute, including parent or stepparent,
      ii. whose gross income for the calendar year in which such taxable year begins is less than the exemption amount (as defined in 26 USC Section 151(d), currently listed as $2000),
      iii. with respect to whom the taxpayer provides over one-half of the individual's support for the calendar year in which such taxable year begins, and
      iv. who is not a qualifying child of such taxpayer or of any other taxpayer for any taxable year beginning in the calendar year in which such taxable year begins.

Direct Contract

An executed agreement between Blue Shield and an individual or group of individual providers for the purpose of providing health care services to Blue Shield enrollees.

Domestic Partner (California Family Code)
An individual who is personally related to the Subscriber by a registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Downstream Entity
All participating providers or other entities contracted or subcontracted with the IPA/medical group, including but not limited to individual physicians, ancillary providers, subcontracted administrative services vendors, third party administrators or management companies, as defined by CMS and the Medicare Advantage regulations.

Durable Medical Equipment (DME)
Equipment designed for repeated use, which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are Durable Medical Equipment such as oxygen ostomy and medical supplies.

Durable Power of Attorney
See *Advance Directives*.

Electronic Claim Submission
Electronic claim submission is the paperless submission of claims generated by computer software that is transmitted electronically to Blue Shield. Claim files are submitted to Blue Shield in the ASC X12 835 5010 format.

Electronic Data Interchange (EDI)
A computer-to-computer exchange of information between businesses. Use of electronic data interchange is considered an industry best-practice to optimize administrative efficiency, lower cost and reduce overall revenue cycle time.

Electronic Funds Transfer (EFT)
EFT is the electronic transfer of claim payments into a designated bank account based on information submitted by the provider. The EFT process is set up to ensure privacy in addition to being quick and efficient.

Electronic Provider Access (EPA)
Electronic Provider Access (EPA) is an online tool giving providers the ability to access out-of-area member's Blue plan provider websites to request medical authorization and pre-service review. To access the EPA tool, log into Provider Connection at www.blueshieldca.com/provider and click on the *Pre-Service Review for Out-of-area Members* within the *Authorizations* section. Choose the *Electronic Provider Access* option and you will be connected directly to the Blue plan within a secured routing mechanism to begin your request.

Electronic Remittance Advice (ERA)
ERA is an electronic version of an explanation of medical payment in HIPAA-compliant files. ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format.

Eligibility Report
A report of members determined by Blue Shield to be eligible for benefits and for whom Blue Shield providers are compensated.

Emergency Services
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.

Employer Group
The organization, firm, or other entity that has at least two employees and who contracts with Blue Shield to arrange health care services for its employees and their dependents.

Essential Community Providers
Healthcare providers that serve predominantly low-income, high-risk, special needs and medically underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.

Evidence of Coverage and Disclosure
A summary of the Plan's coverage and general provisions under the health services contract. The *Evidence of Coverage* includes a description of covered benefits, member cost-sharing, limitations, and exclusion.

Exclusions
An item or service that is not covered by Blue Shield as defined in the *Evidence of Coverage* and *Disclosure.*

Exclusive Provider Organization (EPO)
An Exclusive Provider Organization (EPO) is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

Expedited Appeals
An appeal that requires resolution as soon as possible to accommodate the member's condition not to exceed seventy-two (72) hours from the initial request. To qualify as an expedited appeal, the routine decision-making process might seriously jeopardize the life or health of a person, or when the person is experiencing severe pain.

Expedited Initial Determination
When Blue Shield's routine decision making process might pose an imminent or serious threat to a member's health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function, Blue Shield will make a decision on prior authorization requests relating to admissions, continued stays, or other healthcare services, as soon as medically indicated but no longer than 72 hours.

Expedited Review or Decision
The Knox Keene Act requires and provides for an expedited review (initial determination) and appeal process. When a member believes that his/her health and ability to function could be seriously harmed by waiting 30 days for a standard appeal, he/she may request an expedited review (initial determination) or appeal. NCQA CMS requirements, standards, and Blue Shield require that this request be processed within 72 hours. This request may be filed by the member, his/her representative or his/her physician on behalf of the member.

Experimental/Investigational Treatments
- 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
- Any service that requires federal or state agency approval prior to its use, where such approval has not been granted at the time the service or supply was provided
- 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

Explanation of Benefits (EOB)
A written statement to members identifying which services rendered are covered and not covered under their health plan. Services that are not covered are the member's financial responsibility.

External Independent Medical Review (Blue Shield Medicare Advantage HMO and PPO Plans)

For Blue Shield Medicare Advantage plan members, CMS has contracted with a national independent review body, MAXIMUS Federal Services, Inc. MAXIMUS Federal Services, Inc. is an independent CMS contractor that review appeals by members of Medicare managed care plans, including Medicare Advantage plan.

External Review

An option provided to commercial members for consideration of:

- A medical necessity decision following an appeal;
- An appeal under the Friedman/Knowles Experimental Treatment Act in which care for a member with a terminal illness has been denied on the grounds that the treatment is experimental;
- Where the case is sent to an independent, external review organization for an opinion, which is binding on Blue Shield.

Fee-for-Service

A payment system by Medicare. Fee-for-service doctors, hospitals, and other providers are paid for each service performed. For Blue Shield Medicare Advantage plan, this is also known as traditional or original Medicare.

FEP

The Federal Employee Program.

Formulary

A continually updated list of prescription medications that are approved by the Food and Drug Administration (FDA) and are selected based on safety, effectiveness, and cost for coverage under the Outpatient Prescription Drug program. The list is based on evidence-based review of drugs by members of the Blue Shield Pharmacy & Therapeutics Committee. This Committee is made up of physicians and pharmacists, including practicing network physicians and pharmacists who are not employees of Blue Shield, many of whom are providers and experts in the diagnosis and treatment of disease. The formulary contains both brand-name, generic and biologic drugs.

Fraud, Waste and Abuse (FWA)

Comprehensive program to detect, correct and prevent fraud, waste, and abuse in the Part D benefit.

Functional Acknowledgment (997)

For providers submitting electronic claims, Blue Shield sends a 997 transaction to identify the acceptance or rejection of the functional group, transaction sets or segments.

Grievance
An expression of dissatisfaction by a member, member representative or provider on the member's behalf, and categorized as a potential quality issue, appeal (*see Appeals*) or complaint.

Health Maintenance Organization (HMO)
A health care service plan that requires its members to use the services of designated physicians, hospitals, or other providers of medical care except in a medical emergency. HMOs have a greater control of utilization and typically use a capitation payment system.

Health Services Contract
The employer group or individual contract that establishes the benefits that subscribers and dependents are entitled to receive.

HIPAA (The Health Insurance Portability and Accountability Act of 1996)
HIPAA is the 1996 federal legislation that changes health coverage requirements in the group and individual markets. It contains provisions regarding portability of health coverage, Administrative Simplification, Medical Savings Accounts (MSAs), and fraud and abuse. The Centers for Medicare & Medicaid Services (CMS) is the main regulatory agency responsible for implementing the provisions of HIPAA. The provisions relating to Administrative Simplification were effective in 2002 and 2003. Administrative Simplification is intended to reduce the costs and administrative burdens of health care by establishing national standards (including security) and procedures for electronic storage and transmission of health care information. Administrative Simplification affects health plans, health care providers, and clearinghouses that transmit or collect health information electronically.

HIPAA EDI Validation Report
Blue Shield validates inbound electronic claim files for HIPAA compliance and produces a report to providers submitting electronic claims. Blue Shield utilizes Edifecs as its HIPAA validator.

Hold Harmless
An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed with a Blue plan as full payment for these services.

Home Health Care (HHC)
A comprehensive, medically necessary range of health services provided by a recognized provider organization to a patient at home, usually under the supervision of a physician.

Hospice Care
Care and services provided in a home or facility by a licensed or certified provider that is:
- Designed to be palliative and supportive care to individuals who are terminally ill, and
- Directed and coordinated by medical professionals authorized by the Plan

Hospital
- A licensed and accredited health facility engaged primarily in providing (for compensation from patients) medical, diagnostic, and surgical facilities for the care and treatment of sick and injured members on an inpatient basis, and that provides such facilities under the supervision of a staff of physicians and 24-hour a day nursing services by registered nurses (not including facilities that are principally rest homes, nursing homes, or homes for the aged),
- A psychiatric hospital licensed as a health facility and accredited by a CMS-approved accreditation agency, or
- A "psychiatric health facility" as defined in Section 1250.2 of the Health and Safety Code.

Hospitalist
A physician who specializes in the care of patients who are hospitalized.

In Area
Refers to services performed *within* the Blue Shield service area.

Individual Family Plan (IFP)
A health plan purchased to cover an individual or family, as opposed to a group plan. It differs from a group plan in the following respects: (1) the individual applying for IFP coverage is the contract-holder rather than the employer, (2) underwriting evaluation of a health statement ordinarily is required for everyone to be covered under an IFP contract, and (3) choice of plans is restricted to predetermined benefits.

Infertility
The member who has a current diagnosis of infertility and who is actively trying to conceive and has either:

1. A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
2. The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Initial Decision/Initial Determination
When a physician group, hospital or Blue Shield makes an initial determination for a requested service or a claim for services rendered.

Inpatient
An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

Interchange Acknowledgment (TA1)
For providers submitting electronic claims, Blue Shield provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Limitations
Refers to services that are covered by Blue Shield but only under certain conditions.

Lock-In
A provision for an HMO that requires the member to obtain all medical care through Blue Shield except in the following situations:

- Emergency services, anywhere
- Urgently needed services outside of the service area and (under limited circumstances) inside the service area
- Referrals to non-plan providers or Away-from-Home care

Members that use non-plan providers, except under the conditions mentioned, will be obligated to pay for these services. Neither Blue Shield nor Medicare will pay for these services.

Marketplace Exchange
For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards.

The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a federally facilitated Marketplace in any state that does not do so or will not have an operable Marketplace for the 2014 coverage year, as determined in 2013.

Maximum Enrollee Out-of-Pocket Costs (Blue Shield Medicare Advantage HMO and PPO Plans)

For Blue Shield Medicare Advantage plan members, the maximum out-of-pocket (MOOP) amount is the most that they will pay during the calendar year for in-network covered Medicare Part A and Part B services. Amounts paid for plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. If a Blue Shield Medicare Advantage plan member reaches this amount, they will not have to pay any out-of-pocket costs for the remainder of the year for covered in-network Part A and Part B services. For specific guidelines on how to submit claims for MOOP electronically, contact the EDI Help Desk at (800) 480- 1221.

MAXIMUS Federal Services, Inc. (Blue Shield Medicare Advantage HMO and PPO Plans)

An independent Centers for Medicare & Medicaid Services (CMS) contractor that review appeals by members of Medicare managed care plans, including Blue Shield Medicare Advantage plan.

Medicaid

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women. Medicaid is governed by overall Federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

Medical Necessity

See Section 3.

Medicare Advantage Organization (MAO)

A public or private entity that contracts with CMS to offer a Medicare Advantage plan. Blue Shield of California is a MAO that offers Blue Shield Medicare Advantage HMO and PPO plans.

Medicare Advantage (MA) Program

Section 4001 of the BBA created the MA Program as a new Part C of Title XVIII of the Social Security Act. On June 19, 1998, the Centers for Medicare & Medicaid Services (CMS), issued the regulation implementing the MA Program required by the BBA. Under this program, eligible individuals may elect to receive Medicare benefits through enrollment in one of an array of private health plan choices beyond the original Medicare program or the plans now available through managed care organizations.

Medicare-Covered Charges

The maximum amounts Medicare will pay for Medicare-covered services.

Medicare Crossover
The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

Medicare Guidelines
The rules and regulations used by CMS to determine the services that Medicare covers under Part A (Hospital Insurance protection) and Part B (Medical Insurance protection).

Medicare Part D Covered Drug
A Part D covered drug is available only by prescription, approved by the Food and Drug Administration (FDA) (or is a drug described under section 1927(k)(2)(A)(ii) or (iii) of the Act), used and sold in the United States, and used for a medically accepted indication (as defined in section 1927(k)(6) of the Act). A covered Part D drug includes prescription drugs, biological products, insulin, and medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B as described in specified paragraphs of section 1927(k) of the Act, and vaccines licensed under section 351 of the Public Health Service Act. The definition of a covered Part D drug excludes any drug, biological product, insulin, or vaccine for which as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual. In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act. Medicare Part D excludes fees for drug administration, except for administration fees associated with the administration of a Part D vaccine.

Under Medicare guidelines, some drugs may be covered under Medicare Part B or Medicare Part D depending upon the characteristics of the beneficiary and/or medical use of the drug. Unless otherwise indicated in the Division of Financial Responsibilities, Medicare Part B Covered Services are Group responsibility and Medicare Part D Covered Services are Blue Shield responsibility. Group is delegated for authorization of Medicare Part B drugs. If a drug does not meet LCD Medicare Part B coverage guidelines, Blue Shield will review for potential coverage under Part D, using the LCD Medicare guidelines and Blue Shield prior authorization coverage criteria. An LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).

Medicare Supplemental (Medigap)
Medicare Supplemental (Medigap) pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the "gaps" in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan does not cover.

Medigap policies are regulated under federal and state laws and are "standardized." There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member's Home Plan via Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments, or other cost-sharing.

Member
An individual, either a subscriber or eligible dependent, who is enrolled and maintains coverage in a Blue Shield Plan under the health services contract. This term also applies to Medicare beneficiaries enrolled in the Blue Shield Medicare Advantage plan or a Blue Shield Medicare prescription drug plan.

National Account
An employer group with employee and/or retiree locations in more than one Blue Plan's service area.

National Drug Code (NDC)
The National Drug Code (NDC) is a universal number that identifies a drug or a related drug item. The NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2-digit format.

National Provider Identifier (NPI)
The NPI is a unique 10-digit numeric identification number. The NPI will be issued by CMS to all eligible health care individual practitioners, groups, and facilities. The NPI is required on all HIPAA compliant standard electronic transactions.

Non-Covered Services
Health care services that are not benefits under the subscriber's *Evidence of Coverage/Disclosure Form.*

Opt-Out
The act of a member seeking care without a referral from the primary care physician. Depending upon which type of HMO plan involved, opt-outs might or might not be covered. If covered, members who opt out are responsible for higher out-of-pocket costs. Also called "self-referral."

Other Party Liability (OPL)
A cost containment program that ensures Blue plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers' Compensation, subrogation, and no-fault auto insurance.

Out-of-Area Follow-up Care
Out-of-area services which are non-emergent and medically necessary in nature to establish the member's progress following an initial emergency or urgent service.

Out-of-Pocket Maximum
The highest deductible, copayment and coinsurance amount an individual or family is required to pay for designated covered services each year as indicated in the *Summary of Benefits*. Charges for services that are not covered and charges in excess of the allowable amount or contracted rate do not accrue to the out-of-pocket maximum.

Note: Members are financially responsible for any services which are not covered by the Plan. This may result in total member payments in excess of the out-of-pocket maximum.

Outpatient
An individual receiving services under the direction of a plan provider but not requiring hospital admission.

> *Note:* For Blue Shield Preferred Plans, a length of stay past midnight is considered an inpatient admission.

Outpatient Facility
A licensed facility, not a physician's office or a hospital, which provides medical and/or surgical services on an outpatient basis.

Part B Premium (Blue Shield Medicare Advantage HMO and PPO Plans)
A monthly premium paid (usually deducted from a person's Social Security check) to cover Part B Premiums for Original Medicare fee-for-service. Members of Blue Shield Medicare Advantage plans must continue to pay this premium by themselves, Medicaid, or another third party, to receive full coverage and be eligible to join and stay in Blue Shield Medicare Advantage plans.

Part D Premium (Blue Shield Medicare Advantage HMO and PPO Plans)
Referred to as the Income Related Medicare Adjustment Amount (IRMAA). Beginning in 2011, the Affordable Care Act requires Part D enrollees whose incomes exceed certain thresholds, pay a monthly adjustment amount. This new premium applies to all Medicare beneficiaries, both group and individual, who fall into higher income levels. Like Part B, the premium will usually be deducted from the person's Social Security check.

Participating Provider
A provider who has contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members enrolled in a designated Plan. This definition does not include providers who contract with Blue Shield's mental health service administrator (MHSA) to provide covered mental health or substance use disorder services.

Payor
The entity that accepts the financial risk for the provision of health care services.

Peer Review
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 the performance of colleagues by professionals with similar types and degrees of expertise.

Percent of Billed Charges
A payment arrangement under which a provider is reimbursed at a previously agreed upon percentage of the total billed amount, not to include non-benefit items or items previously excepted from the payment arrangement.

Per Diem Rate
A negotiated rate per day for payment of all covered inpatient services provided to a patient in a preferred hospital.

Physician Advisor Review
A physician review of a utilization management request for prospective, concurrent and/or retrospective reviews for the purpose of determining medical necessity and/or appropriateness of care or services.

Plan
The member's health care service plan, e.g., HMO, PPO, EPO, and POS.

Plan Hospital
A hospital licensed under applicable state law contracting with Blue Shield specifically to provide HMO Plan benefits to members.

Plan Provider
A provider who has an agreement with Blue Shield to provide covered services to HMO members.

Plan Specialist
A physician (M.D. or D.O.) other than a primary care physician, who has an agreement with Blue Shield to provide covered services to HMO members according to an authorized referral by a primary care physician, or according to the Access+ *Specialist* program, or during a well-woman examination.

Point-of-Service (POS)
A type of managed care plan whereby members have the option of choosing to obtain covered medical services from the provider of their choice from a provider within Blue Shield network or from an out-of-network provider, or through their primary care physician who manages their care and refers members to participating hospitals, physicians, and other providers within a select HMO network. POS members who obtain their medical care through their primary care physician receive HMO level benefits. Members who self-refer to in-network or out-of-network providers are subject to applicable deductibles, copayments, and coinsurance. Care received from out-of-network providers is covered at the lowest benefit level. When members receive services from out-of-network providers they are financially responsible for the difference between the amount Blue Shield allows for those services and the amount billed by the out-of-network provider. Mental health and substance use disorder services are provided at the HMO and PPO non-participating levels of care.

Preferred Provider Organization (PPO)
A network of providers (usually physicians, hospitals, and allied health care professionals) that contract with a payor to deliver services to the enrollees of a designated health care service plan. These providers agree to accept the payor's allowances plus any enrollee coinsurance, copayment, or deductible as payment in full.

Preferred Provider Organization, Basic (PPOB)
A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.

Prefix
Three characters preceding the subscriber identification number on the Blue plan ID cards. The prefix identifies the member's Blue plan or national account and is required for routing claims.

Prescription Drug Plan (PDP)
Medicare Part D prescription drug coverage that is offered under a policy, contract or plan that has been approved by the Centers for Medicare & Medicaid Services (CMS) as specified in 42 C.F.R. § 423.272 to offer qualified prescription drug coverage.

Primary Care Physician (PCP)
A general practitioner, board-certified (if not board certified, must at least have completed a two-year residency program) eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with Blue Shield through an IPA/medical group to provide benefits to members and to refer, authorize, supervise, and coordinate the provision of all benefits to members in accordance with their health services contract and the Plan service delivery guidelines.

Provider Connection
Blue Shield's provider website at www.blueshieldca.com/provider.

Provider Inquiry
A telephoned or written request from a provider to explain the rationale for a decision to reduce, delay, or deny services or benefits. This inquiry may or may not alter the original decision.

Provider Manual
The *Hospital and Facility Guidelines* manual, which sets forth the operational rules and procedures applicable to the hospital and the performance of services described in the hospital agreement and which is amended and updated by Blue Shield at least annually. The Provider Manual shall include the rules, regulations or policies adopted by Blue Shield, including Blue Shield's payment and medical policies, which may, from time to time, be communicated to physicians and providers.

Psychiatric Emergency Medical Condition
A mental health disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

A) An immediate danger to himself or to herself, or to others.
B) Immediately unable to provide for, or utilize, food, shelter, or clothing due to the mental disorder.

Qualified Health Plan (QHP)
Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Quality Improvement Organization (QIO)
A group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare. QIOs work under the direction of the Centers for Medicare & Medicaid Services (CMS) to assist Medicare providers with quality improvement and to review quality concerns for the protection of beneficiaries and the Medicare Trust Fund. Formerly known as a Peer Review Organization (PRO). Health Services Advisory Group (HSAG) is the QIO for California.

Reasonable Layperson
A non-medically trained individual using reasonable judgement under the circumstances. For emergency services, coverage is provided when a member reasonably would believe that an emergency situation exists.

Referral
The process by which a member obtains authorization for covered services rendered by providers other than the member's primary care physician.

Referred Services
A covered health service, performed by a referred-to provider, which is:

- Authorized in advance by the primary care physician and/or the IPA/medical group
- Limited in scope, duration, or number of services, as authorized

Referred-To Provider
A provider to whom a member is referred for services.

Rehabilitation Service
Inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illness and Severe Emotional Disturbances of a Child, to restore an individual's ability to function to the maximum extent practical. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

Residential Care
Mental Health or Substance Use Disorder services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for members who do not require acute inpatient care.

Secure File Transfer Protocol (SFTP)
A service (communication protocol) specially designed to establish a connection to a particular computer, so that files can be securely transferred between computers. This protocol encrypts the data transferred to the receiving computer and prevents unauthorized access during the operation.

Service Area (Blue Shield Medicare Advantage HMO and PPO Plans)
The geographic area in which a person must permanently reside in to be able to become or remain a member of a Blue Shield Medicare Advantage plan. Blue Shield Medicare Advantage plans have multiple service areas within California. The specific service area in which the member permanently resides determines the Medicare Advantage plan(s) in which they may enroll. More than one Blue Shield Medicare Advantage plan may be offered in a service area.

Service Area (HMO)
The geographic area as defined in the Blue Shield HMO contract generally considered to be located within a 30-mile radius from the IPA/medical group's primary care physician facilities.

If members receive care outside their primary care physician's service area, it must be for an urgent or emergency condition or authorized by their primary care physician. When processing claims and encounters, the zip code of the attending physician (for professional claims) or the billing provider (for facility claims) is compared to the IPA/medical group's table of zip codes stored in Blue Shield's system to determine if the claim is for out-of-area services.

Shared Savings Services
Covered services paid by Blue Shield from a budget that is subject to a periodic settlement. Any surplus or deficit from this budget is shared between the IPA/medical group and Blue Shield.

Skilled Nursing Facility (SNF)
A facility with a valid license issued by the California Department of Public Health as a "Skilled Nursing Facility" or any similar institution licensed under the laws of any other state, territory, or foreign country. Also included is a Skilled Nursing Unit within a Hospital.

State Children's Health Insurance Program (SCHIP)
SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

Stop-Loss
A contractual agreement with day or dollar threshold criteria that allows payment beyond the normal case or per-diem rate.

Sub-Acute Care
Skilled nursing or skilled rehabilitative care provided in a hospital or skilled nursing facility to patients who require skilled care such as nursing services; physical, occupational, or speech therapy; a coordinated program of multiple therapies; or who have medical needs that require daily monitoring by a registered nurse. A facility that is primarily a rest home, convalescent facility, or home for the aged is not included in this definition.

Subscriber
A group employee or individual who is enrolled in and maintains coverage under the health services contract.

Third Party Liability
A provision of the health services contract that allows recovery of reasonable costs from a third party when a member is injured through the act or omission of a third party.

Traditional Coverage
Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance, or copayments.

Unsolicited Claim Status Inquiry Report (U277) v 4040
Blue Shield validates inbound electronic claim files for HIPAA compliance and returns results back to submitters in an ASCX12 U277 file format. Blue Shield utilizes Claredi Corporation's Faciledi as its HIPAA validator.

Urgent Services
Those covered services rendered outside of the primary care physician's service area (other than Emergency Services) which are medically necessary to prevent serious deterioration of a member's health resulting from unforeseen illness, injury, or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the member returns to the primary care physician's service area.

Validation Reports
Blue Shield generates a validation report for electronic submitters of claims and encounters summarizing the number of claims and encounters that have been received and processed.

Appendix For Section 2

There is no appendix for Section 2.

Appendix for Section 2

This page intentionally left blank.

There is no appendix for Section 3.

Appendix for Section 3

This page intentionally left blank.

Table of Contents

Appendix for Section 4

This page intentionally left blank.

Reimbursement for Outpatient Services

Reimbursement for outpatient services is based on a facility's contractual agreement in effect at the time services are rendered. To receive payment, facilities must properly identify services provided by submitting a completed UB-04 (or successor), or other HIPAA-compliant claim form and include all applicable codes (Revenue, CPT/HCPCS, modifiers) for each service. Revenue Codes should be appropriate for the bill type.

Blue Shield periodically reviews, and makes appropriate updates to, procedure listings based on industry standards. Updated listings are provided electronically and available upon request. Please consult your Blue Shield Network Manager for verification of your negotiated payment schedule.

Blue Shield reimburses facilities for outpatient services rendered to Blue Shield members using a variety of payment terms, including but not limited to: case rates, per visit rates, fee schedules, APC payment rate, and percentage of charges. In calculating allowed amounts, Blue Shield may round the figure to the nearest whole dollar. Please refer to your agreement to determine the reimbursement structure applicable to each outpatient service.

To complement the agreement, each section below provides:

A. **A summary of the reimbursement method**
B. **A calculation example(s)**

For outpatient services reimbursed pursuant to the APC payment rate, please refer to Section X of this document.

I. OUTPATIENT SURGICAL SERVICES

A. Summary

Blue Shield has implemented a payment system for outpatient surgical services that classifies ambulatory procedures into related groups. The groups are based on the relative resource needs (costs) for that group of procedures. The core of this payment system is the CPT-specific coding. Facilities must bill with appropriate revenue codes, CPT/HCPCS codes and modifiers in order to receive applicable payment. Blue Shield reimburses facilities for outpatient surgical services using one of the following payment methodologies:

- **Outpatient Surgical Grouper Schedule**
- **APG Payment Schedule**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes. If your facility is reimbursed under a fee schedule methodology, please see your fee schedule for a complete listing of CPT/HCPCS Codes.

To access your fee schedule, you can search and download the updated files on Provider Connection at www.blueshieldca.com/provider under *Claims, Facility and professional fee schedules,* then *View facility fee schedules*. Instructions are provided as well as a link to the *Provider Name Fee Schedule Crosswalk* that identifies the specific fee schedule assigned to you.

You may also request a CD version of the updated fee schedule(s) be mailed to you by emailing facilityfeeschedules@blueshieldca.com.

If you have questions about updates to the fee schedules, please contact your Blue Shield Provider Relations Coordinator.

I. OUTPATIENT SURGICAL SERVICES *(cont'd.)*

B. Examples of Reimbursement Calculation

Facilities contracting with Blue Shield under the Outpatient Surgical Grouper Schedule or APG Payment Schedule methodologies utilize reimbursement calculations resembling the examples below.

Outpatient Surgical Grouper Schedule

SURGICAL SERVICES OUTPATIENT SURGICAL GROUPER SCHEDULE CALCULATION EXAMPLE		
Formula	Facility Payment = (Outpatient Surgical Group Index Fee) x (Regional Factor) x (Multiplier)	
Example Assumptions	• Revenue code billed is 0360 • CPT code billed is 10022 • CPT code 10022 is assigned to Outpatient Surgical Group 1 • Outpatient Surgical Group 1 has an **Outpatient Surgical Index Fee** of **$340** • Hospital is in XYZ county, which has a **Regional Factor** of **1.176** • Hospital's negotiated **Multiplier** is **2.00**	
Total Case Rate Payment = $340 x 1.176 x 2.00 = (The case rate payment may be rounded to the nearest whole dollar.)		**$799.68**

APG Payment Schedule

SURGICAL SERVICES APG PAYMENT SCHEDULE CALCULATION EXAMPLE		
Formula	Facility Payment = (APG Grouper (corresponding APG Weight)) x (APG Payment Rate)	
Example Assumptions	• Revenue code billed is 0360 • CPT code billed is 10021 • CPT code 10021 is assigned to Grouper 001 • Grouper 001 has a **weight** of **0.2000** • Hospital's negotiated value of **APG at 1.0000** (APG Payment Rate) is **$1,000**	
Total Case Rate Payment = 0.2000 x $1,000 = (The case rate payment may be rounded to the nearest whole dollar.)		**$200**

II. OUTPATIENT EMERGENCY SERVICES AND URGENT CARE SERVICES

A. Summary

Reimbursement for Emergency Services is based on the level of care provided to a Blue Shield member. Level of care varies from Level 1 (Limited) to Level 4 (Critical). Facilities must bill with applicable revenue codes, CPT/HCPCS codes and modifiers in order to receive reimbursement.

Blue Shield reimburses facilities for outpatient Emergency Services and Urgent Care Services using, generally, one of the following payment methodologies:

- **Case Rate**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required revenue and CPT/HCPCS codes.

B. Example of Reimbursement Calculation

Facilities contracting with Blue Shield under the case rate methodology utilize reimbursement calculations resembling the example below.

EMERGENCY SERVICES AND URGENT CARE SERVICES CASE RATE CALCULATION EXAMPLE		
Formula	Facility Payment = (Case Rate) x (Multiplier)	
Example Assumptions	• Revenue code billed is 0450 • CPT Code billed is 99281, which is Level 1: Limited • The **Case Rate** for Level 1 is **$97** • Hospital's negotiated **multiplier** is **2.00**	
Total Case Rate Payment = $97 x 2.00 = (The case rate payment may be rounded to the nearest whole dollar.)		**$194**

III. DIALYSIS SERVICES

A. Summary

Blue Shield reimburses facilities for outpatient Dialysis Services using one of the following payment methodologies:

- **Per Visit Rate (excluding Pharmaceuticals)**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes.

B. Example of Reimbursement Calculation

For Facilities Under a Per Visit Rate Agreement

For each day of, or visit for, Dialysis covered services provided on an outpatient basis by a facility to a member, Blue Shield will pay the facility the per visit rate multiplied by the negotiated dialysis multiplier, as set forth in your agreement.

Please see Section VIII, Outpatient Pharmaceutical Services, for specific details and calculation examples regarding pharmaceutical reimbursement.

Facilities contracting with Blue Shield under the per visit rate methodology utilize reimbursement calculations resembling the example below.

DIALYSIS SERVICES PER VISIT RATE CALCULATION EXAMPLE		
Formula	Facility Payment = (per visit rate) x (Multiplier)	
Example Assumptions	• Revenue code billed is 0829, which is Mobile Dialysis • The **per visit rate** for Mobile Dialysis is **$300** • Hospital's negotiated **Multiplier** is **1.10**	
Total Per Visit Payment = $300 x 1.10 = (The per visit payment may be rounded to the nearest whole dollar.)		**$330**

IV. OUTPATIENT INFUSION THERAPY SERVICES

A. Summary

Blue Shield reimburses facilities for outpatient Infusion Therapy Services using one of the following payment methodologies:

- **Per Visit Rate (excluding Pharmaceuticals)**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes.

Compensation for the facility's provision of outpatient Infusion Therapy Services provided to HMO or Medicare Advantage members is generally the financial responsibility of the member's IPA or medical group.

B. Example of Reimbursement Calculation

For Facilities Under a Per Visit Rate Agreement

For each day of, or visit for, Infusion Therapy covered services provided on an outpatient basis by a facility to a member, Blue Shield will pay the facility the per visit rate.

Please see Section VIII, Outpatient Pharmaceutical Services, for specific details and calculation examples regarding pharmaceutical reimbursement.

Facilities contracting with Blue Shield under the per visit rate methodology utilize reimbursement calculations resembling the example below.

INFUSION THERAPY SERVICES PER VISIT RATE CALCULATION EXAMPLE		
Formula	Facility Payment = the per visit rate set forth in the agreement	
Example Assumptions	• Revenue code billed is 0261, which is an Infusion Therapy revenue code • Hospital's negotiated **per visit rate** is **$250**	
Total Per Visit Payment =		**$250**

V. OUTPATIENT PHYSICAL, RESPIRATORY, SPEECH, AND OCCUPATIONAL THERAPY SERVICES

A. Summary

Blue Shield reimburses facilities for outpatient Physical, Respiratory, Speech, and Occupational Therapy Services using one of the following payment methodologies:

- **Per Visit Rate**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes.

Compensation for the facility's provision of outpatient Physical Therapy, Respiratory Therapy, Speech Therapy, and Occupational Therapy Services provided to HMO or Medicare Advantage members is generally the financial responsibility of the member's IPA or medical group.

B. Example of Reimbursement Calculation

For Facilities Under a Per Visit Rate Agreement

For Physical, Respiratory, Speech, and Occupational Therapy covered services provided by the facility to a member, Blue Shield will pay the facility the per visit rate.

Facilities contracting with Blue Shield under the per visit rate methodology utilize reimbursement calculations resembling the example below.

RESPIRATORY THERAPY SERVICES PER VISIT RATE CALCULATION EXAMPLE		
Formula	Facility Payment = the negotiated per visit rate set forth in your agreement	
Example Assumptions	• Revenue code billed is 0412, which is a Respiratory Therapy revenue code • Hospital's negotiated **per visit rate** is **$75**	
Total Per Visit Payment =		**$75**

VI. OUTPATIENT RADIOLOGY, PATHOLOGY, AND DIAGNOSTIC TEST SERVICES

A. Summary

For the facility and technical component of covered outpatient Radiology, Pathology, and Diagnostic Test Services provided by the facility to a member, Blue Shield reimburses facilities in accordance with the following methodologies:

- **Outpatient Radiology, Pathology, and Diagnostic Test Services Fee Schedule**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of Revenue and CPT/HCPCS Codes. If your facility is reimbursed under a fee schedule methodology, please see your fee schedule for a complete listing of CPT/HCPCS Codes.

To access your fee schedule, you can search and download the updated files on Provider Connection at www.blueshieldca.com/provider under *Claims, Facility and professional fee schedules,* then *View facility fee schedules*. Instructions are provided as well as a link to the *Provider Name Fee Schedule Crosswalk* that identifies the specific fee schedule assigned to you.

You may also request a CD version of the updated fee schedule(s) be mailed to you by emailing facilityfeeschedules@blueshieldca.com.

If you have questions about updates to the fee schedules, please contact your Blue Shield Provider Relations Coordinator.

B. Example of Reimbursement Calculation

For agreements with diagnostic services reimbursed under fixed payment methodologies, the following formulas are used to calculate reimbursements:

OUTPATIENT RADIOLOGY, PATHOLOGY, AND DIAGNOSTIC TEST SERVICES FEE SCHEDULE		
Formulas	Facility Payment = (a + b) x (Conversion Factor) x (Multiplier) *where:* (a) = (Practice Expense Technical Component based on the Outpatient Radiology, Pathology and Diagnostic Tests Schedule) x (Practice Regional Factor for the region in which the hospital facility providing the service is located) *(subject to rounding)* (b) = (Malpractice Expense Technical Component based on the Outpatient Radiology, Pathology and Diagnostic Tests Schedule) x (Malpractice Regional Factor for the region in which the hospital facility providing the service is located) *(subject to rounding)*	
Example Assumptions	• Revenue code billed is 0310 • CPT code billed is 70470, which has the following values: • **Practice Expense Technical Component = 7.100** • **Malpractice Expense Technical Component = 0.370** • County is XYZ has the following factors: • **Practice Regional Factor = 1.235** • **Malpractice Regional Factor = 0.669** • **Conversion Factor = $40.6978** • Hospital's negotiated **Multiplier is 1.00**	
Calculating (a): (a) = (7.100 x 1.235) = 8.7685		
Calculating (b): (b) = (0.370 x 0.669) = 0.24753		
Payment = (8.7685 + 0.24753) x ($40.6978) x (1.00) = (9.01603) x ($40.6978) x (1.00) = (The payment may be rounded to the nearest whole dollar.)		**$366.93**

VII. OUTPATIENT CLINICAL LABORATORY SERVICES

A. Summary

Blue Shield reimburses facilities for outpatient Clinical Laboratory Services using one of the following payment methodologies:

- **Clinical Laboratory Fee Schedule**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes. If your facility is reimbursed under a fee schedule methodology, please see your fee schedule for a complete listing of CPT/HCPCS Codes.

To access your fee schedule, you can search and download the updated files on Provider Connection at www.blueshieldca.com/provider under *Claims, Facility and professional fee schedules,* then *View facility fee schedules*. Instructions are provided as well as a link to the *Provider Name Fee Schedule Crosswalk* that identifies the specific fee schedule assigned to you.

You may also request a CD version of the updated fee schedule(s) be mailed to you by emailing facilityfeeschedules@blueshieldca.com.

If you have questions about updates to the fee schedules, please contact your Blue Shield Provider Relations Coordinator.

B. Example of Reimbursement Calculation

For Facilities Using a Clinical Laboratory Fee Schedule

For the facility and technical component of all outpatient laboratory covered services provided by the hospital to a member, Blue Shield will pay the facility using the Clinical Laboratory Fee Schedule multiplied by the negotiated Hospital Specific Multiplier, as set forth in your agreement.

Facilities contracting with Blue Shield under the Clinical Laboratory Fee Schedule methodology utilize reimbursement calculations resembling the examples below.

CLINICAL LABORATORY SERVICES CLINICAL LABORATORY SCHEDULE CALCULATION EXAMPLE		
Formula	Facility Payment = (Clinical Laboratory Fee Schedule Rate) x (Multiplier)	
Example Assumptions	• Revenue code billed is 0300 • CPT code billed is 80053 • The **Clinical Laboratory Fee Schedule** rate for this CPT code is **$14.77** • Hospital's negotiated **Multiplier** is **2.00**	
Total Payment for CPT code 80053 = $14.77 x 2.00 = (The calculation may be rounded to the nearest whole dollar.)		**$29.54**

VIII. OUTPATIENT PHARMACEUTICAL SERVICES

A. Summary

Blue Shield reimburses facilities for outpatient Pharmaceutical Services using the following payment methodologies:

- **Outpatient Pharmaceutical Fee Schedule**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes. If your facility is reimbursed under a fee schedule methodology, please see your fee schedule for a complete listing of CPT/HCPCS Codes.

Blue Shield's AWP-based Outpatient Pharmaceutical Fee Schedule is updated quarterly to capture changes to AWP pricing. To access your fee schedule, you can search and download the updated files on Provider Connection at www.blueshieldca.com/provider under *Claims, Facility and professional fee schedules, View facility fee schedules*, then *Pharmaceutical fee schedules*.

If you have questions about these updates to the fee schedules, please contact your Blue Shield Provider Relations Coordinator.

B. Example of Reimbursement Calculation

For Facilities Using the Outpatient Pharmaceutical Fee Schedule

The Blue Shield Outpatient Pharmaceutical Fee Schedule is based on the Average Wholesale Price (AWP). The AWP shall be derived from nationally recognized pricing sources selected by Blue Shield and shall be updated by Blue Shield quarterly. For new drugs, or drugs that are unclassified, the facility must bill using the appropriate revenue code, unclassified CPT-4/HCPCS code, and NDC Code with description in order to receive payment.

Facilities contracting with Blue Shield under the Pharmaceutical Fee Schedule methodology utilize reimbursement calculations resembling the example below.

PHARMACEUTICAL SERVICES OUTPATIENT PHARMACEUTICAL FEE SCHEDULE CALCULATION EXAMPLE		
Formula	Facility Payment = (Outpatient Pharmaceutical Fee Schedule) x (number of units)	
Example Assumptions	• HCPCS code billed is J0282 • The **Outpatient Pharmaceutical Fee Schedule** rate for J0282 is **$1.39** per unit • **Units billed** = **5**	
Total Payment = $1.39 x 5 = (The payment may be rounded to the nearest whole dollar.)		**$6.95**

IX. OTHER OUTPATIENT SERVICES

A. Summary

Blue Shield will compensate the facility for other covered outpatient services provided to a member not referenced under any specific outpatient services payment category at allowed charges minus the negotiated discount percentage. In many cases, reimbursement for these services will not exceed the Medical/ Surgical/ Pediatric Per Diem Rate set forth in your agreement.

Please review your agreement's specific terms for details.

X. OUTPATIENT SERVICES REIMBURSED AT APC PAYMENT RATE

A. Summary

Blue Shield reimburses pursuant to the Outpatient Fee Schedule using the following payment methodologies:

- **Outpatient Pharmaceutical Fee Schedule**
- **Percentage of Charges**

B. Example of Reimbursement Calculation

Services Assigned a Rate on the Outpatient Fee Schedule

OUTPATIENT FEE SCHEDULE ASSIGNED RATE CALCULATION EXAMPLE		
Formula	Facility Payment = (Outpatient Fee Schedule) x (Multiplier)	
Example Assumptions	• CPT code billed is 20999 • The rate for CPT code 20999 is $1500 • Hospital's Multiplier is 1.05	
Total Payment = $1,500 x 1.05 = $1,575 (The payment may be rounded to the nearest whole dollar)		**$1,575**

Services Reimbursed at POC Pursuant to the Outpatient Fee Schedule

OUTPATIENT FEE SCHEDULE POC CALCULATION EXAMPLE		
Formula	Facility Payment = (Allowed Charges) x (Base) x (Multiplier)	
Example Assumptions	• CPT code billed is 58150 • Hospital's Allowed Charges are $2,000 • Hospital's Base Percentage is 10.2% • Hospital's Multiplier is 1.05	
Total Payment = $2,000 x 10.2% x 1.05 **= $2,000 x .102 x 1.05 =** (The payment may be rounded to the nearest whole dollar)		**$214.20**

Skilled Nursing Facility Discharges (SNF or TCU)

Background

There have been longstanding federal regulations designed to protect member rights for Medicare Advantage (MA) enrollees. These regulations include the right to due process, with appeal rights when any service or item being denied or as cited in section 422.568(c) of the Balanced Budget Act, when a discontinuation of a service occurs and the member disagrees.

For skilled nursing facility discharges, discontinuation of service, continued stay beyond the maximum Medicare/Blue Shield Medicare Advantage plan covered benefit of 100 days per benefit period, a specific, regulatory notice is required to be provided to the beneficiary (member) (or legal representative) and said notice requires a signed acknowledgement of receipt.

What constitutes a valid acknowledgement of receipt?

The Centers for Medicare & Medicaid Services (CMS) has external review performed through Maximus Federal Services (Maximus). We are summarizing from Maximus "Reconsideration Notes", the guidelines for appropriate notice of receipt of the Notice of Non-Coverage (NONC) for SNF discharges. Signature validates receipt of the notice but does not imply any agreement. The notice ties to delivery of member rights and for a notice to be considered to have occurred, the following guidelines apply:

- Delivery in person is preferable and the member must sign the actual notice. For appeals cases, the plan must provide a copy of the actual notice delivered, not a sample letter, along with the signature page, with the member signature, acknowledging receipt.
- If a member refuses to sign an acknowledgment of receipt of the Notice of Non-Coverage, both the beneficiary's medical chart and the "refusal to sign" page of the notice should reflect:
    - The date the notice was delivered.
    - The individual who delivered the notice.
    - Specific reasons for the member's refusal to sign the notice receipt acknowledgment form.
    - If a witness is able to attest a patient's refusal to sign, document the delivery of the notice and obtain the witness's signature as attestment to the patient's refusal to sign.
    - If a witness is not available, the individual delivering the notice should sign the acknowledgment form to attest the attempted delivery of the Notice of Non-Coverage.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

- Enhancements to build on the acknowledgment of receipt in the case of a refusal to sign:
    - Often, a verbal notice of a planned discharge occurs prior to delivery of the actual written notice. Although not required, if a verbal notice occurs, it can be easily noted on the Acknowledgment of Receipt page prior to delivery of the notice to the member. By noting the verbal notice on the acknowledgment of receipt, the case documentation is enhanced, should an issue be subsequently appealed.

      Note: Verbal notice does not meet the requirements for valid notice. Verbal notice can only be used to enhance the case documentation related to the actual delivery of a valid notice with a signed acknowledgement of receipt.

Guardians and Incompetent Patients

A notice is not valid if delivered knowingly to an incompetent patient. Having a patient being discharged from skilled nursing care with a diagnosis of dementia is not likely to hold as a valid notice on appeal unless there are documented attempts to also deliver the Notice of Non-Coverage (NONC) to and secure a signed acknowledgment from any legal guardian or other family members.

Legal guardians include court appointed guardians, family members with Durable Power of Attorney for Health Care, or appropriate legal counsel/attorney representation. Additionally, it is also recognized that, as a practical matter, there are circumstances when appointment documentation cannot be obtained in a timely manner. If a member is not competent or is physically unable to sign the statement, and the representative is the spouse or next of kin, the notice acknowledgement that is signed by a default representative should be clearly documented by the facility as to the applicability of a state allowable person to be a default representative. In the event there is any controversy related to such default representation, only a representative as determined by the appropriate state court would be accepted.

If verbal or telephonic notice is provided to a representative, this is only as back up to the actual signed acknowledgement of written notice. The member officially receives notice when the written notice is delivered and a signed acknowledgement obtained or a clearly documented refusal to sign the acknowledgement occurs.

We are challenged when a guardian is unwilling to sign the acknowledgment of receipt of the notice and direct hand delivery is not viable. In such cases, document all attempts to both verbally inform and to physically deliver the notice carefully. If delivery of the notice to a guardian for an incompetent patient is via mail, keep all receipts from the courier service or certified mail (return receipt required) to demonstrate delivery of the notice.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

In such cases, the signed courier service or other confirmation of delivery can be submitted as valid acknowledgement of receipt.

- The patient's chart should document any verbal notice
- Document attempted delivery to member and guardian
- Obtain signed acknowledgement of receipt or document (and preferably witness) actual delivery of the notice, where there is a refusal to sign

Note: In cases where care must be coordinated through an offsite guardian, provide adequate time for delivery of a valid notice. (A courier service delivery will delay notice and potentially discharge by only one day if they are able to deliver to the guardian. U.S. Certified mail is not as predictable.)

Regulatory Changes and the Centers for Medicare & Medicaid Services

Important Notice. The Grijalva Final Rule 42 C.F.R. § 422.620 contains provisions required under the settlement agreement in the Grijalva v. Shalala litigation concerning appeal rights under the Medicare managed care program to Medicare Advantage (MA) enrollees at the time of discharge from an inpatient hospital stay. For the Grijalva portion, which relates to SNF, Home Health and CORF discharges, the effective date was January 1, 2004. The current requirement still in effect for IPAs is to deliver the Notice of Non-Coverage (NONC) within one day prior to the effective date of the discharge.

The Final Rule Requires:

- The right to an immediate review of a Medicare Advantage Organization (MAO) discharge decision by an independent review body if the enrollee believes services should continue.
- Advanced written notice to all MA enrollees **at least two days before** the termination of certain services (before planned termination of Medicare coverage of their skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services), with instructions on how to obtain a detailed notice and file an appeal.
- Upon request, a specific and detailed explanation of why services are either no longer medically necessary or are no longer covered by the health plan. The health plan also needs to describe any applicable Medicare coverage rule, MA policy, contract provision or rationale upon which the termination decision was based.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Regulatory Changes & the Centers for Medicare & Medicaid Services *(cont'd.)*

In addition, the final rule requires MAOs to provide detailed discharge notices only in those situations where enrollees indicate dissatisfaction with the health plan's decision. All Medicare beneficiaries who are treated in a hospital will continue to receive generic notices upon admission that will inform them of their appeal rights, but only those beneficiaries that disagree with the decision to be discharged must be issued a detailed written notice of non-coverage one day before their hospital coverage ends. If an appeal is filed, beneficiaries remain entitled to continuation of coverage for their hospital stay until the quality improvement organization renders a decision.

Enrollees then may request an independent review of the MA organization's decision to end coverage of SNF, HHA or CORF services. In the event of a timely appeal request, an MA organization must issue a second, detailed notice that explains the reasons why Medicare coverage should end.

CMS has designated Quality Improvement Organizations (QIOs) to conduct these fast-track reviews. QIOs are suitable for the fast-track appeals process in light of their experience in performing similar, immediate reviews of inpatient hospital discharges. The QIO that has an agreement with the SNF, HHA, or CORF providing the enrollee's services will process the appeal. The MA organization must provide the second, detailed notice to both the QIO and the enrollee.

Provider Notification of Termination. An important feature of the final rule provisions is that Medicare would charge providers with the actual delivery of the required notices. CMS believes that the providers themselves are in the best position to deliver the notices to enrollees, and that it would be placing an unreasonable burden on MAO's to require that they deliver the notices to affected enrollees. The MA organization would retain ultimate responsibility for the decision to terminate services and for financial coverage of the services, however. The services would remain covered until four calendar days after an enrollee receives the termination notice, or if the Independent Review Entity reviews the decision, until noon on the day after an Independent Review Entity decision upholding the MAO's decision. CMS believes that the requirement that providers issue these notices, in effect on behalf of MAO's, best ensures that beneficiaries receive these notices in a timely manner. To facilitate implementation of this policy, we are proposing under §422.502(l) that all contracts between MAO's and their providers must specify that the providers will comply with the notice and appeal provisions in subpart M of the federal requirements.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Regulatory Changes & the Centers for Medicare & Medicaid Services *(cont'd.)*

Timing of Notices. Section 422.624(b)(1) addresses the timing of the required notices. In general, the provider would notify the enrollee of the MAO's decision to terminate covered services two calendar days before the scheduled termination. Again, the current requirement still in effect is within one day of the date of discharge. If the provider services are expected to be furnished to an enrollee for a time span of fewer than two calendar days in duration, the enrollee should be given the notice upon admission to the provider (or at the beginning of the service period if there is no official ''admission'' to a non-institutional provider, such as in an HHA setting). The notice must be given in all situations, regardless of whether an enrollee agrees with the decision that his or her services should end.

CMS would allow providers a full working ''day'' within which to deliver the termination notice, with any notification delivered during normal business hours on a given day serving to initiate the four-day standard on that day, even if the timing of the delivery of the notice resulted in fewer than 24 hours to ask for an Independent Review Entity appeal, and fewer than 96 hours between notification and the proposed termination of services. That is, a notice delivered to a member at 2 p.m., Monday, would indicate that the member has until noon, Tuesday, to appeal to the Independent Review Entity, with termination of services scheduled for noon, Friday.

Delivery of Notices. §422.624(c) specifies that ''delivery'' of a notice is valid only if a member has signed and dated the notice to indicate that he or she both received the notice and can comprehend its contents. This policy is consistent with our requirements governing delivery of similar notices, such as the requirements set forth in HCFA Program Memoranda A-02-018 for HHA Advanced Beneficiary Notices. Under this concept, a member who is comatose, confused, or otherwise unable to understand or act on his or her rights could not validly ''receive'' the notice, necessitating the presence of an authorized representative for purposes of receiving the notice. Similarly, presenting the standardized notice to a person who is illiterate, blind, or unable to understand English would not constitute successful ''delivery'' of the notice. Such situations could be remedied either through use of an authorized representative if that person has no barriers to receiving the notice or through other steps (such as use of a translator or language accessible version of the notice) that overcome the difficulties associated with notification.

> *Note:* CMS would not interpret the requirement for successful delivery to permit an enrollee to extend coverage indefinitely by refusing to sign a notice of termination. If an enrollee refuses to sign a notice, the provider would annotate its copy of the notice to indicate the refusal, and the date of the refusal would be considered the date of receipt of the notice. Paragraph (c) describes what constitutes an effective delivery of a termination notice. The notice would have to be delivered timely, using standardized format and language, and include all of the elements required under §422.624(b)(2).

BLUE SHIELD OF CALIFORNIA
APPEAL PROCESS FOR NOTICE OF NON-COVERAGE HHA, SNF, CORF

# ___	Responsible Party	Activity	Time Requirement
___	MSO	Determines termination date and drafts Notice of Medicare Non-Coverage (NOMNC). Faxes to SNF, HHA, CORF. If SNF, HHA, CORF prepare their own notices then notification needs to be given for termination date.	No less than 2 days prior to termination of services
1.	SNF, HHA, CORF	Issues NOMNC and obtains member's signature. SNF- at least 2 days prior to termination If < 2 days of service, then on admission or first visit, if the enrollee's services are expected to be fewer than 2 days in duration, the SNF, HHA, or CORF should notify the enrollee at the time of admission to the provider. If, in a non-institutional setting, the span of time between services exceeds two days, the provider should deliver the notice no later than the next to last time that services are furnished. If benefits are exhausted a notice is required, the member may appeal, however these are referred back to the health plan to review and respond to this appeal. If a HHA is going out for an evaluation only, the agency is not required to send a notice. Also when only partial services are being discontinued (i.e., PT ends, but HHC continues), no notice is needed until all services end.	2 days prior to termination of services
2.	Enrollee	Disagrees with the discharge, the enrollee must contact the Quality Improvement Organization (QIO), Health Services Advisory Group, Inc. This request is made either in writing, telephone or fax, by noon the day after receipt of the NOMNC. The notice is still considered timely as long as Health Services Advisory Group, Inc. receives the appeal request no later than noon the day before the effective date that Medicare coverage ends.	No later than noon the day after receipt of notice
3.	QIO = Health Services Advisory Group, Inc.	Receives Appeal request from enrollee or representative. Immediately notifies Medicare Advantage and the provider of the enrollee's request for a fast track appeal by phone and fax.	Day 1 begins
4.	MA (Medicare Advantage) = Medicare Advantage plan	Receives notice of appeal from Health Services Advisory Group, Inc. (by phone & fax) requesting the following information for review: A copy of the advance notice of termination (NONMC), a copy of the detailed explanation of Non-coverage (DENC), a copy of enrollee's medical records, and a copy of other documents as requested.	Day 1

#	Responsible Party	Activity	Time Requirement
5.	Blue Shield Medicare Advantage plan	Contact CM at IPA/MSO and request the information above faxed to Health Services Advisory Group, Inc. for review. Advise of same day requirement for sending these records. Request coversheet confirming records were sent to Health Services Advisory Group, Inc., copy of NONMC and DENC faxed to Blue Shield Medicare Advantage plan. Also contact should be made to SNF requesting records & NOMNC be faxed to Health Services Advisory Group, Inc. for review with confirmation of this to Blue Shield. Health Services Advisory Group, Inc. needs the detailed chart notes that SNF's have for review.	Day 1
6.	Blue Shield Medicare Advantage plan	If IPA/MSO is unable to make Day 1 submission requirement, notify Manager, Director or Medical Director.	Day 1
7.	Blue Shield Medicare Advantage plan	Manager, Director or Medical Director then contacts IPA Director of UM/QM & or Medical Director to obtain documents.	Day 1
8.	IPA/MSO	Faxes records to: 1.) Health Services Advisory Group, Inc. Copy of NOMNC with member's signature or documentation of refusal to sign, copy of DENC and copy of enrollee's medical records. 2.) Member/representative: Mails DENC. Upon request, all documents sent to Health Services Advisory Group, Inc.	Day 1
9.	Blue Shield Medicare Advantage plan	IPA makes decision to rescind the termination date and send new letter to member Fax copy of letter to Health Services Advisory Group, Inc.	Resolved Go to step 14
10.	Health Services Advisory Group, Inc.	Reviews documents Renders decision to uphold or overturn Notifies Blue Shield Medicare Advantage plan of decision by phone or fax. Mails letters of determination to Blue Shield Medicare Advantage plan and enrollee	Day 1 If Resolved Go to step 14
11.	Health Services Advisory Group, Inc.	If documents not received by Health Services Advisory Group, Inc., on Day 2, Health Services Advisory Group, Inc. sends to Blue Shield Medicare Advantage plan , "Notice: Failure to Comply" requesting documents again.	Day 2

Blue Shield Medicare Advantage Plan
Required Billing Elements

#	Responsible Party	Activity	Time Requirement
12.	Blue Shield Medicare Advantage plan	Call IPA/MSO contact again to ensure all documents are faxed to Health Services Advisory Group, Inc. for review.	Day 2
13.	Health Services Advisory Group, Inc.	Review documents Render decision to uphold or overturn Notifies IPA & Blue Shield Medicare Advantage plan of decision by phone or fax. Mails letters of determination to Blue Shield Medicare Advantage plan and enrollee	Day 2
14.	Blue Shield Medicare Advantage plan	Logs all actions, dates & times in Notes document Prepare file for each appeal with notes on left side of folder, all other documents are filed on right side of folder, latest on top Record case in Grijalva Appeals tracking log	Real time
15.	Blue Shield Medicare Advantage plan	Cases are filed away in a locked cabinet alphabetically	Conclusion

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Contractual and Billing Requirements

Contracts already obligate providers to compliance with state and federal regulations. As part of the new CMS rule, contracted entities must comply with applicable notice and appeal provisions in subpart M, including but not limited to, the notification requirements in §§422.620 and 422.624 and the requirements in §422.626 concerning supplying information to an Independent Review Entity.

Questions & Answers:

Is the provider or MA organization required to obtain an enrollee's signature on the advance termination notice or detailed termination notice?

The provider must obtain the enrollee's or authorized representative's signature on the advance termination notice (NOMNC), which ensures that the enrollee received the notice, and that financial liability may be properly transferred to the enrollee for any days beyond the effective date that Medicare coverage ends. The provider must place the original NOMNC in the enrollee's case file, and give a copy to the enrollee. In the event of an appeal, the provider must also provide a copy to the Quality Improvement Organization (QIO), since the QIO is responsible for verifying that the provider delivered a valid notice to the enrollee.

The MA organization does not need to obtain the enrollee's or authorized representative's signature on the detailed notice, which is called the Detailed Explanation of Non-Coverage (DENC).

Suppose that an enrollee is receiving physical therapy, wound care, and IV in a SNF. If the SNF only discontinues the IV, is the SNF required to deliver an NOMNC to the enrollee two days prior to the IV ending?

No. A provider is not required to deliver the NOMNC two days prior to one service ending, while other Medicare-covered services continue. The fast-track appeals process applies only to situations when the enrollee will no longer receive Medicare-covered services from the provider. The scenario described would be considered a reduction, rather than a termination, of services.

Many patients receiving home health care only require a single visit. Can the NOMNC be given during the first (and last) visit?

Yes. In cases where the services or visits will be less than two days, the NOMNC may be given upon admission, or during the only visit.

If a member is in a SNF, gets pneumonia and subsequently needs to go to an acute setting, should the member receive the NOMNC?

No. The NOMNC is not intended or required for this situation.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Contractual & Billing Requirements *(cont'd.)*

Will SNFs, HHAs, and CORFs be required to retain copies of NOMNCs in patients' medical records? Will the MA organization need to obtain a copy?

The provider should retain a copy of the NOMNC as part of the patient's medical record; however, MAO's and providers should determine how and where the notices should be maintained to meet medical records' retention policies.

If a provider is discontinuing a previously authorized, discrete increment of services, e.g., the MA organization authorized 12 skilled nursing visits by an HHA nurse, does the provider still have to issue a NOMNC if the provider is planning to discharge the patient as scheduled on the last visit? Why?

Yes. The provider must deliver the NOMNC no later than the next-to-last visit in this example. Providing a notice to the enrollee not only conveys when the services are going to end, but also informs the enrollee of the right to appeal if the enrollee disagrees, and transfers liability to the enrollee if the enrollee continues to receive non-covered services.

Can you please clarify whether the fast-track appeals process also includes psychiatric home health services?

Yes, the fast-track appeals process applies to psychiatric home health services.

How will providers know what their responsibilities are under the new fast-track appeals process?

CMS provides information to providers on their responsibilities under this new appeals process through CMS' Medlearn website, CMS' "list serve" of participating providers, outreach to provider trade associations, and CMS open door forums. In addition, we are instructing our fiscal intermediaries and carriers to include an article about the process in their next provider bulletins. QIOs are also required to provide education and training to the providers with whom they have agreements. MAO's must also do their part to ensure that their providers are educated about their responsibilities under the fast-track appeals process.

Will CMS release the NOMNC to providers, or will MAO's be required to distribute the notices to the providers directly?

The notices are available online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-nomnc-denc. MAO's should work with their providers to determine whether direct distribution is necessary. The provider education material that we have distributed refers providers to the "appeals" website.

CMS Model Letters:

- **DETAILED NOTICE OF DISCHARGE (Attachment A)**
- **NOTICE OF MEDICARE NON-COVERAGE (Attachment B)**

(Attachment A – CMS Model Letter – **SAMPLE -** Must be 12 point font)

Patient Name: **OMB Approval No. 0938-1019**
Patient ID Number: Date Issued:
Physician:

[Insert Hospital or Plan Logo here]
DETAILED NOTICE OF DISCHARGE

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____. This is based on Medicare coverage policies listed below and your medical condition. **This is not an official Medicare decision.** The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  ____Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

  ____Medicare Managed Care policies, if applicable:

  _____
  [Insert specific managed care policies]

  ____Other _____
  [Insert other applicable policies]

- Specific information about your current medical condition:

  _____

- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call **[insert hospital and/or plan telephone number]**.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. CMS 10066 (approved 5/2007)

Blue Shield Medicare Advantage Plan
Required Billing Elements

(Attachment B – CMS Model Letter – **SAMPLE -** Must be 12 point font)
OMB Approval No. 0938-0953

[Insert provider contact information here]
NOTICE OF MEDICARE NON-COVERAGE

Patient name: **Patient number:**

The Effective Date Coverage of Your Current [insert type]
Services Will End: [insert effective date]

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current [insert type] services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above.
- Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: Health Services Advisory Group of California, Inc., 1-800-841-1602, TTY 1-800-881-5980, to appeal, or if you have questions.

See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953
H0504_12_095B File & Use 05052012

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

If you have Original Medicare: Call the QIO listed on page 1.

If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information:

Blue Shield Medicare Advantage Plan
Attn: Medicare Appeals and Grievances Dept.
P.O. Box 927
Woodland Hills, CA 91365-9856

Ph: 1-800-776-4466
TTY: 1-800-794-1099
Fax: 1-916-350-6510

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative Date
Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

Optional Attachment to assist with documentation

Blue Shield Medicare Advantage Plan
Required Billing Elements

Please fax completed (signed) Notice of Medicare Non-Coverage (NOMNC) to:

_____

CONFIRMATION OF NOTICE BY TELEPHONE

(Notification by telephone is done only in situations where the notice must be delivered to an incompetent enrollee in an institutional setting. See *Medicare Managed Care Manual*, Chapter 13, Section 60.1.3 for reference.)

Name of person contacted:

Date of contact: Time: ☐AM ☐PM

_____ _____

Signature of Health Plan/SNF/HHA/CORF/Medical Group Representative Date

CONFIRMATION OF FOLLOW-UP NOTICE BY MAIL

(Notification by mail must also be done if telephone notification was made. This is done only in situations where the notice must be delivered to an incompetent enrollee is in an institutional setting. See Medicare Managed Care Manual, Chapter 13, Section 60.1.3 for reference.)

Mailing address:

_____

_____+_____

Date sent: _____Via: ☐ US Mail ☐ Certified Mail ☐ FedEx ☐ Priority Mail

Tracking # (if applicable): _____

CONFIRMATION OF REFUSAL TO SIGN

I confirm that the Notice of Medicare Non-Coverage was hand-delivered to the member or the member's authorized representative; however, the member or the member's authorized representative refused to sign the acknowledgment of receipt.

Name of person receiving notice:

Date of delivery: Time: ☐AM ☐PM

_____ _____

Signature of Person Delivering Notice Date

Blue Shield Medicare Advantage Plan
Required Billing Elements

Guidance Checklist When Issuing NOMNC to Other Than Member (See Medicare Managed Care Manual, Chapter 13, Section 60.1.3)	Responsible Party		Initial Completed	Date	Time
	SNF	BSC/IPA /MG			
Call patient's representative the day letter is issued. (Date of conversation is the date of the receipt of the NONMC). ID self and give organization, contact name and number, purpose of call (right to file an appeal) and describe the appeal right being discussed (e.g., QIO vs. expedited).					
Inform representative that skilled services will no longer be covered beginning on: (date) _____ and financial responsibility starts on (date) _____.					
Advise representative of appeal rights. (You must read directly from the letter.)					
Advise representative that an appeal must be phoned to HSAG by 12:00 p.m. the following day of receipt of the NOMNC or phone call.					
Provide the representative with the QIO name (HSAG) and phone number listed in the appeal section of the letter. Provide address, fax or other method of communication needed by representative for QIO to receive appeal in a timely fashion.					
Inform representative how to get a detailed notice describing why the enrollee's services are not being covered.					
Provide at least one phone number of an advocacy organization or 1-800-MEDICARE.					
Confirm the telephone contact by written notice mailed same day.					
If direct phone contact cannot be made, including leaving voice mail, mail the notice to the representative, certified mail, return receipt requested. (If the **Medical Group** is sending the certified mail, the Facility must notify the Medical Group immediately that certified mail is required.) (If the **Facility** sent the certified mail, and HSAG is processing an appeal, the certified returned receipt must be submitted to HSAG. If not submitted, the appeal may be decided in favor of the member solely due to lack of the receipt which is the evidence of timely notification.)					
Document that representative understands the information provided.					

This page intentionally left blank.

Where to Send Claims

Hospitals and facilities are asked to submit Blue Shield claims electronically that do not have a medical record attached. Electronically submitted claims will be acknowledged within 2 days. Claims are submitted in the ASC X12 837 5010 format. Blue Shield has contracted with several vendors for providers to submit claims at no cost. Electronic claims can also be submitted directly to Blue Shield via secure file transfer protocol (SFTP) using one of their own dedicated static IP addresses.

To enroll in electronic claim submission, providers can use any approved clearinghouse listed on Provider Connection. Providers can submit claims at no charge using vendors Office Ally, TriZetto Provider Solutions or Ability Network. These vendors can be contacted at www.blueshieldca.com/provider in the *Claims* section under *How to submit claims* or by contacting the EDI Department at (800) 480-1221.

If you need to submit paper claims with medical records, use the Claims Routing Tool, located on Provider Connection at blueshieldca.com/provider under the *Claims* tab, to determine the correct mailing address for each member. Because claims mailing addresses are different for different Blue Plan members, using the Claims Routing Tool is the most accurate way to determine a claim mailing address.

Where to Send Claims

If you are unable to access the Claims Routing Tool, please use the specific P.O. Box numbers listed on this page. If the subscriber's group is not listed, use the **All Other Blue Shield Plans** P.O. Box number shown below.

BLUECARD OUT-OF-AREA PROGRAM
Check subscriber ID for three-letter prefix before sending
Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630
(800) 622-0632

CALPERS
(California Public Employees Retirement System)
Blue Shield of California
CalPERS
P. O. Box 272540
Chico, CA 95927-2540
(800) 541-6652

FEDERAL EMPLOYEE PROGRAM (FEP)
Subscriber ID number begins with the letter "R"
FEP
P.O. Box 272510
Chico, CA 95927-2510
(800) 824-8839

BLUE SHIELD MEDICARE ADVANTAGE
Blue Shield Medicare Advantage plan
P. O. Box 272640
Chico, CA 95927
(800) 541-6652
Fax (818) 228-5104

INITIAL PROVIDER APPEAL AND RESOLUTION
Blue Shield of California
P. O. Box 272620
Chico, CA 95927-2620

FINAL PROVIDER APPEAL AND RESOLUTION
(Commercial Only)
Blue Shield of California
P.O. Box 629011
El Dorado Hills, CA 95762-9011

SHORT-TERM CLAIMS FOR BLUE SHIELD LIFE & HEALTH INSURANCE COMPANY
P. O. Box 9000
London, KY 40742

ALL OTHER BLUE SHIELD PLANS
Blue Shield of California
P. O. Box 272540
Chico, CA 95927-2540
(800) 541-6652

Where to Send Claims for Foundations for Medical Care

When the name of a medical foundation appears on a subscriber's identification card, the benefits for that subscriber are administered by that foundation. Forward all claims to that foundation for payment.

The medical foundations with which Blue Shield is affiliated are listed below:

Foundation for Medical Care of Tulare & Kings Counties, Inc.

Address: 3335 South Fairway
Visalia, CA 93277
Phone: **(800) 662-5502**
(559) 734-1321
Fax: (559) 734-3828

Foundation for Medical Care of Mendocino-Lake Counties

Address: 620 S. Dora St., Suite 201
Ukiah, CA 95482-5482
Phone: **(707) 462-7607**

This page intentionally left blank.

List of Incidental Procedures

CPT	Description
10004	Fna bx w/o img gdn ea addl
10006	Fna bx w/us gdn ea addl
10008	Fna bx w/fluor gdn ea addl
10010	Fna bx w/ct gdn ea addl
10012	Fna bx w/mr gdn ea addl
10036	Perq dev soft tiss add imag
11045	Deb subq tissue add-on
11046	Deb musc/fascia add-on
11047	Deb bone add-on
11103	Tangntl bx skin ea sep/addl
11105	Punch bx skin ea sep/ addl
11107	Incal bx skn ea sep/addl
15772	Grfg autol fat lipo ea addl
15774	Each addl 25cc
15777	Acellular derm matrix implt
15853	Removal Sutr/Stapl Xreq Anes
15854	Remove Sutr & Stapl Xreq Anes
19030	Injection for breast x-ray
19082	Bx breast add Lesion strtctc
19084	Bx breast add Lesion US imag
19086	BX breast add lesion MR imag
19281	Perq device breast 1st imag
19282	Perq device breast ea imag
19283	Perq dev breast 1st strtctc
19284	Perq dev breast add strtctc
19285	Perq dev breast 1st US imag
19286	Perq dev breast add US imag
19287	Perq dev breast 1st mr guide
19288	Perq dev breast add mr guide
20501	Inject sinus tract for x-ray
20700	Prep and insert drug del device
20701	Removal (deep)
20702	Prep and insert drug del device
20703	Removal (intramedullary)
20704	Prep and insert drug del device
20705	Removal (intra-articular)
20932	Osteoart algrft w/surf & b1
20933	Hemicrt intrclry algrft prtl
20934	Intercalary algrft compl
20985	Cptr-asst dir ms px
21116	Injection, jaw joint x-ray
22552	Addl neck spine fusion
22853	Insj Biomechanical Device
22854	Insj Biomechanical Device
22859	Insj Biomechanical Device
22868	Insj Stablj Dev W/dcmprn
22870	Insj Stablj Dev w/o Dcmprn

CPT	Description
23350	Injection for shoulder x-ray
24220	Injection for elbow x-ray
25246	Injection for wrist x-ray
27093	Injection for hip x-ray
27095	Injection for hip x-ray
27369	Njx Cntrst kne arthg/ct/mri
27648	Injection for ankle x-ray
31627	Navigational bronchoscopy
31649	Bronchial valve remov init
31651	Bronchial valve remov addl
32506	Wedge resect of lung add-on
32507	Wedge resect of lung diag
33508	Endoscopic vein harvest
33866	Aortic hemiarch graft
35572	Harvest femoropopliteal vein
36000	Place needle in vein
36005	Injection ext venography
36010	Place catheter in vein
36011	Place catheter in vein
36012	Place catheter in vein
36013	Place catheter in artery
36014	Place catheter in artery
36015	Place catheter in artery
36100	Establish access to artery
36140	Establish access to artery
36160	Establish access to aorta
36200	Place catheter in aorta
36215	Place catheter in artery
36216	Place catheter in artery
36217	Place catheter in artery
36218	Place catheter in artery
36245	Place catheter in artery
36246	Place catheter in artery
36247	Place catheter in artery
36248	Place catheter in artery
36251	Ins cath ren art 1st unilat
36252	Ins cath ren art 1st bilat
36253	Ins cath ren art 2nd+ unilat
36254	Ins cath ren art 2nd+ bilat
36299	Vessel injection procedure
36400	Bl draw < 3 yrs fem/jugular
36405	Bl draw < 3 yrs scalp vein
36406	Bl draw < 3 yrs other vein
36410	Non-routine bl draw > 3 yrs
36416	Capillary blood draw
36474	Endovenous Mchnchem Add-On
36481	Insertion of catheter, vein

List of Incidental Procedures

CPT	Description
36500	Insertion of catheter, vein
36510	Insertion of catheter, vein
36591	Draw blood off venous device
36592	Collect blood from picc
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
37247	Trluml Balo Angiop Addl Art
37249	Trluml Balo Angiop Addl Vein
37252	Intravasc us noncoronary 1st
37253	Intravasc us noncoronary addl
38200	Injection for spleen x-ray
38790	Inject for lymphatic x-ray
38792	Identify sentinel node
38794	Access thoracic lymph duct
38900	Io map of sent lymph node
42550	Injection for salivary x-ray
44701	Intraop colon lavage add-on
47001	Needle biopsy, liver add-on
49327	Lap ins device for rt
49400	Air injection into abdomen
49412	Ins device for rt guide open
49424	Assess cyst, contrast inject
49427	Injection, abdominal shunt
50606	Endoluminal bx urtr rnl plvs
50684	Injection for ureter x-ray
50690	Injection for ureter x-ray
50705	Ureteral embolization/occl
50706	Balloon dialate urtrl strix
51600	Injection for bladder x-ray
51605	Preparation for bladder xray
51610	Injection for bladder x-ray
51701	Insert bladder catheter
51702	Insert temp bladder cath
54230	Prepare penis study
55300	Prepare, sperm duct x-ray
58340	Catheter for hysterography
61781	Scan proc cranial intra
61782	Scan proc cranial extra
61783	Scan proc spinal
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
64634	Destroy c/th facet jnt addl
64636	Destroy l/s facet jnt addl
64643	Chemodenerv 1 extrem 1 - 4 ea
64645	Chemodenerv 1 extrem 5/> ea

CPT	Description
66990	Ophthalmic endoscope add-on
68850	Injection for tear sac x-ray
69990	Microsurgery add-on
78808	Iv inj ra drug dx study
92973	Percut coronary thrombectomy
92974	Cath place, cardio brachytx
93462	L hrt cath trnsptl puncture
93463	Drug admin & hemodynmic meas
93561	Cardiac output measurement
93562	Cardiac output measurement
93563	Inject congenital card cath
93564	Inject hrt congntl art/grft
93565	Inject l ventr/atrial angio
93566	Inject r ventr/atrial angio
93567	Inject suprvlv aortography
93568	Inject pulm art hrt cath
93569	Njx Cth Slct P-Art Angrp Uni
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93573	Njx Cath Slct P-Art Angrp Bi
93574	Njx Cath Slct Pulm Vn Angrph
93575	Njx Cath Slct P Angrph Mapca
95940	Ionm in operating room 15 min
95941	Ionm remote/>1 pt per hour
96904	Whole body photography
96934	Rcm celulr subcelulr img skn
96935	Rcm celulr subcelulr img skn
96936	Rcm celulr subcelulr img skn
0042T	Ct perfusion w/contrast, cbf
0054T	Bone surgery using computer
0055T	Bone surgery using computer
0095T	Each additional interspace
0098T	Each additional interspace
0198T	Ocular blood flow measure
0348T	Rsa spine exam
0349T	Rsa upper extr exam
0350T	Rsa lower extr exam
0397T	Ercp w/optical endomicroscpy
0437T	Impltj Synth Rnfcmt Abdl Wal
0439T	Myocrd Contrast Prfuj Echo
0444T	1st Plmt Drug Elut OC Ins
0445T	Sbsqt plmt Drug Elut OC Ins
0466T	Insj ch wal respir eltrd/ra
0513T	Esw integ wnd hlg ea addl
0523T	Ntrapx c ffr w/3d funcil map
0602T	Transdermal GFR Measurements
0603T	Transdermal GFR Monitoring

List of Incidental Procedures

CPT	Description
0604T	Rem Oct Rta Dev Setup & Education
0605T	Rem Oct Rta Tech support Min 8
0615T	Eye movement alys w/o calbrj I&R
0777T	R-t prs sensing edrl gdn sys
A4337	Incontinent rectal insert
A4435	1 pc ost pch drain hgh output
A4555	Ca tx e-stim electr/transduc
A4650	Implant radiation dosimeter
A7027	Combination oral/nasal mask
A9575	Inj gadoterate meglumi 0.1ml
A9581	Gadoxetate disodium inj
A9582	Iodine I-123 iobenguane
A9583	Gadofosveset trisodium inj
C1822	Gen, neuro, hf, rechg bat
C5272	Low cost skin substitute app
C5274	Low cost skin substitute app
C5276	Low cost skin substitute app
C5278	Low cost skin substitute app
C9143	Cocaine hcl nasal (numbrino)
C9144	Inj, bupivacaine (posimir)
C9254	Inj, lacosamide
C9359	Porous purifi colgn matrx bone vd filler
C9363	Skin sub,(meshd wound matrx)
C9364	Porcine implnt (permacol)
C9756	Fluorescence lymph map w/icg
E0766	Elec stim cancer treatment
G0316	Prolong inpt eval add 15 m
G2211	Complex e/m visit add on
G2212	Prolong outpt/office visit
G2213	Initiat med assist tx in er
L8604	Inject bulk agent,dextranomer acid,1ml
Q4100	Skin substitute, NOS
Q4101	Apligraf skin sub
Q4102	Oasis wound matrix skin sub
Q4103	Oasis burn matrix skin sub
Q4104	Integra BMWD skin sub
Q4105	Integra DRT skin sub
Q4106	Dermagraft skin sub
Q4107	Graftjacket skin sub
Q4108	Integra matrix skin sub
Q4110	Primatrix skin sub
Q4111	Gammagraft skin sub
Q4112	Cymetra allograft

CPT	Description
Q4113	Graftjacket express allograf
Q4114	Integra flowable wound matri
Q4115	Alloskin skin sub
Q4116	Alloderm skin sub
S9433	Medical food oral 100% nutr

This page intentionally left blank.

List of Office-Based Ambulatory Procedures

CPT	Description
10021	Fna w/o image
10040	Acne surgery
10060	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10120	Remove foreign body
10160	Puncture drainage of lesion
11000	Debride infected skin
11055	Trim skin lesion
11056	Trim skin lesions, 2 to 4
11057	Trim skin lesions, over 4
11200	Removal of skin tags
11201	Remove skin tags add-on
11300	Shave skin lesion
11301	Shave skin lesion
11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion
11312	Shave skin lesion
11313	Shave skin lesion
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
11730	Removal of nail plate
11740	Drain blood from under nail
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesions injection
11921	Correct skin color defects
11922	Correct skin color defects
11950	Therapy for contour defects
11951	Therapy for contour defects
11952	Therapy for contour defects
11954	Therapy for contour defects
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12004	Repair superficial wound(s)
12011	Repair superficial wound(s)
12013	Repair superficial wound(s)

CPT	Description
12014	Repair superficial wound(s)
12015	Repair superficial wound(s)
15783	Abrasion treatment of skin
15786	Abrasion, lesion, single
15787	Abrasion, lesions, add-on
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
16000	Initial treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
16030	Treatment of burn(s)
17000	Destroy benign/premlg lesion
17003	Destroy lesions, 2-14
17004	Destroy lesions, 15 or more
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17108	Destruction of skin lesions
17110	Destruct lesion, 1-14
17111	Destruct lesion, 15 or more
17250	Chemical cautery, tissue
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
17999	Skin tissue procedure
19000	Drainage of breast lesion
19001	Drain breast lesion add-on
20500	Injection of sinus tract
20526	Ther injection, carp tunnel
20527	Inj dupuytren cord w/enzyme
20550	Inj tendon sheath/ligament
20551	Inj tendon origin/insertion
20552	Inj trigger point, 1/2 muscl
20553	Inject trigger points, =/> 3
20555	Place ndl musc/tis for rt
20560	Ndl insert w/o inj 1 or 2 muscles
20561	Ndl insert w/o inj 3 or more muscles
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20606	Drain/inj joint/bursa w/us
20610	Drain/inject, joint/bursa
20611	Drain/inj joint/bursa w/us
20612	Aspirate/inj ganglion cyst
20615	Treatment of bone cyst
20950	Fluid pressure, muscle

List of Office-Based Ambulatory Procedures

CPT	Description
20974	Electrical bone stimulation
20979	Us bone stimulation
24640	Treat elbow dislocation
24650	Treat radius fracture
25500	Treat fracture of radius
25530	Treat fracture of ulna
25560	Treat fracture radius & ulna
25600	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25630	Treat wrist bone fracture
25650	Treat wrist bone fracture
26010	Drainage of finger abscess
26340	Manipulate finger w/anesth
26341	Manipulat palm cord post inj
26600	Treat metacarpal fracture
26641	Treat thumb dislocation
26670	Treat hand dislocation
26700	Treat knuckle dislocation
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
26750	Treat finger fracture, each
26755	Treat finger fracture, each
26770	Treat finger dislocation
27200	Treat tail bone fracture
27220	Treat hip socket fracture
27256	Treat hip dislocation
27899	Leg/ankle surgery procedure
28430	Treatment of ankle fracture
28450	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28570	Treat foot dislocation
28600	Treat foot dislocation
28630	Treat toe dislocation
28660	Treat toe dislocation
29000	Application of body cast
29010	Application of body cast
29015	Application of body cast
29035	Application of body cast

CPT	Description
29040	Application of body cast
29044	Application of body cast
29046	Application of body cast
29049	Application of figure eight
29055	Application of shoulder cast
29058	Application of shoulder cast
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29086	Apply finger cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29240	Strapping of shoulder
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29305	Application of hip cast
29325	Application of hip casts
29345	Application of long leg cast
29355	Application of long leg cast
29358	Apply long leg cast brace
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29445	Apply rigid leg cast
29450	Application of leg cast
29505	Application, long leg splint
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29580	Application of paste boot
29581	Apply multlay comprs lwr leg
29700	Removal/revision of cast
29705	Removal/revision of cast
29710	Removal/revision of cast
29720	Repair of body cast
29730	Windowing of cast
29740	Wedging of cast
29750	Wedging of clubfoot cast

List of Office-Based Ambulatory Procedures

CPT	Description
29799	Casting/strapping procedure
30300	Remove nasal foreign body
30901	Control of nosebleed
31231	Nasal endoscopy, dx
31242	Nasal/sinus ndsc dstrj ablation
31243	Nasal/sinus ndsc dstrj cryoablation
31298	Nasal sinus endoscopy surgical
31502	Change of windpipe airway
31575	Diagnostic laryngoscopy
32550	Insert pleural catheter
32552	Remove lung catheter
32553	Ins mark thor for rt perq
32562	Lyse chest fibrin subq day
36430	Blood transfusion service
36465	Inj noncompounded foam sclerosant
36466	Inj noncompounded foam sclerosant
36593	Declot vascular device
36598	Inject rad eval central venous device
36680	Insert needle, bone cavity
40800	Drainage of mouth lesion
40804	Removal, foreign body, mouth
40830	Repair mouth laceration
41019	Place needles h & n for rt
42280	Preparation, palate mold
42400	Biopsy of salivary gland
42809	Remove pharynx foreign body
42975	Dise eval slp do brth flx dx
43752	Nasal/orogastric w/stent
43753	Tx gastro intub w/asp
43754	Dx gastr intub w/asp spec
43755	Dx gastr intub w/asp specs
43756	Dx duod intub w/asp spec
43757	Dx duod intub w/asp specs
43761	Reposition gastrostomy tube
44705	Prepare fecal microbiota
45520	Treatment of rectal prolapse
46600	Diagnostic anoscopy
46601	Diagnostic anoscopy
46900	Destruction, anal lesion(s)
46916	Cryosurgery, anal lesion(s)
50391	Instll rx agnt into rnal tub
50686	Measure ureter pressure
51100	Drain bladder by needle
51700	Irrigation of bladder
51705	Change of bladder tube
51720	Treatment of bladder lesion

CPT	Description
51736	Urine flow measurement
51741	Electro-uroflowmetry, first
51784	Anal/urinary muscle study
51792	Urinary reflex study
51797	Intraabdominal pressure test
51798	Us urine capacity measure
52284	Cysto w/dilat rx balo cath
53454	Tprnl balo cntnc dev adjmt
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
53860	Transurethral rf treatment
54050	Destruction, penis lesion(s)
54056	Cryosurgery, penis lesion(s)
54200	Treatment of penis lesion
54235	Penile injection
54240	Penis study
54250	Penis study
55000	Drainage of hydrocele
55920	Place needles pelvic for rt
56820	Exam of vulva w/scope
56821	Exam/biopsy of vulva w/scope
57100	Biopsy of vagina
57150	Treat vagina infection
57156	Ins vag brachytx device
57160	Insert pessary/other device
57170	Fitting of diaphragm/cap
57420	Exam of vagina w/scope
57421	Exam/biopsy of vag w/scope
57452	Exam of cervix w/scope
57455	Biopsy of cervix w/scope
57505	Endocervical curettage
58100	Biopsy of uterus lining
58110	Biopsy of uterus lining add on
58300	Insert intrauterine device
58301	Remove intrauterine device
58321	Artificial insemination
58322	Artificial insemination
58323	Sperm washing
58580	Trnscervical abltn uterine fibroid
59020	Fetal contract stress test
59025	Fetal non-stress test
59050	Fetal monitor w/report
59051	Fetal monitor/interpret only
59200	Insert cervical dilator
59412	Antepartum manipulation

List of Office-Based Ambulatory Procedures

CPT	Description
59425	Antepartum care only
59430	Care after delivery
59899	Maternity care procedure
60100	Biopsy of thyroid
60300	Aspir/inj thyroid cyst
64405	N block inj, occipital
64445	N block inj, sciatic, sng
64454	Inj Aa&/Strd Genicular nrv brnch
64455	N block inj, plantar digit
64596	Insj/rplcmt perq eltrd rap n w/nstim
64611	Chemodenerv saliv glands
64615	Chemodenerv musc migraine
64616	Chemodenerv musc neck dyston
64617	Chemodenerv muscle laryny EMG
64624	Dest Neurolytic agt Genicular nrv
64632	N block inj, common digit
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65430	Corneal smear
65778	Cover eye w/membrane
65779	Cover eye w/membrane stent
67500	Inject/treat eye socket
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67800	Remove eyelid lesion
67805	Remove eyelid lesions
67810	Biopsy of eyelid
68040	Treatment of eyelid lesions
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68761	Close tear duct opening
69000	Drain external ear lesion
69020	Drain outer ear canal lesion
69090	Pierce earlobes
69200	Clear outer ear canal
69209	Remove impacted ear wax uni
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
90867	Tcranial magn stim tx plan
90868	Tcranial magn stim tx deli
92132	Cmptr ophth dx img ant segmt

CPT	Description
92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92537	Caloric vstblr test w/rec
92538	Caloric vstblr test w/rec
93050	Art pressure waveform analys
93464	Exercise w/hemodynamic meas
97597	Active wound care/20 cm or <
97598	Active wound care > 20 cm
0071T	Focused ultrasnd abl,uterine leiomyomata
0072T	Total leiomyomata vol,200cc tissue
0207T	Clear eyelid gland w/heat
0213T	Njx paravert w/us cer/thor
0214T	Njx paravert w/us cer/thor
0215T	Njx paravert w/us cer/thor
0216T	Njx paravert w/us lumb/sac
0217T	Njx paravert w/us lumb/sac
0218T	Njx paravert w/us lumb/sac
0219T	Plmt post facet implt cerv
0220T	Plmt post facet implt thor
0221T	Plmt post facet implt lumb
0222T	Plmt post facet implt addl
0272T	Interrogate crtd sns dev
0273T	Interrogate crtd sns w/pgrmg
0278T	Tempr
0331T	Heart symp image plnr
0332T	Heart symp image plnr spect
0378T	Visual field assmnt rev/rprt
0379T	Vis field assmnt tech suppt
0419T	Dstrj Neurofibroma Xtnsv
0420T	Dstrj Neurofibroma Xtnsv
0474T	Insj aqueous drg dev io rsvr
0529T	Interrog dev eval iims ip
0530T	Removal complete iims
0563T	Evac Meibomian gld heat bilat
0566T	Auto cell implt adps tiss njx imp knee
0588T	Rev or rem isdns post tibial nrv
C7513	Cath/angio dial cir w/aplasty
C7514	Cath/angio dial cir w/stents
C7515	Cath/angio dial cir w/embol
C8929	Transthoracic Echo, w or w/o contrst followd with
C8930	Transthoracic Echo, w or w/o cntrst followd inc record

Instructions for Completing a UB-04 Form

Form Locator	Instructions
FL01	**Billing Provider Name, Street Address and Telephone Number** Enter the billing provider's name, city, state, and nine-digit ZIP Code
FL02	**Billing Provider's Designated Pay to Name** Not applicable
FL03a	**Patient Control Number** Enter the patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes.
FL03b	**Medical/Health Record Number** Enter the number assigned to the patient's medical/health record by the provider
FL04	**Type of Bill** Enter the four-digit alphanumeric code. The 4th digit indicates the sequence of the bill in the episode of care and is referred to as a "frequency" code. If the 4th digit is billed as 0 (zero), the claim is defined as a "Nonpayment/Zero Claims" and will not be considered for payment.
FL05	**Federal Tax ID** Enter the Tax ID Number *Note:* If this data element is not provided, Blue Shield will consider this as an unclean claim and will return for correction.
FL06	**Statement Covers Period – From/Through** Enter the beginning and ending dates of the period included on the bill in numeric fields (MMDDYY)
FL07	**Reserved for Assignment by NUBC** Not applicable

FL08 **Patient Name**

Enter the patient's last name, first name, and, if any, middle initial, along with patient identifier (if different than the subscriber/insured's identifier).

Name on Baby's Claim

When submitting a separate claim for a level two, three or four NICU newborn, enter the baby's name rather than "baby boy" or "baby girl." In the case of twins, indicate the baby's name rather than "Baby A" or "Baby B." Blue Shield will return the unprocessed claim if the baby's name is missing.

FL09 **Patient Address**

Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and ZIP Code.

FL10 **Patient Date of Birth**

Enters the patient's date of birth.

FL11 **Patient Sex**

Enter the sex of the patient.

FL12 **Admission/Start of Care Date**

Enter the date the patient was admitted for inpatient care (MMDDYY). The HHA enters the same date of admission that was submitted on the RAP for the episode.

FL13 **Admission Hour**

Enter the two-digit military time code to indicate the admission hour.

FL14 **Type of Admission**

Enter the Type of Admission

FL15 Source of Referral for Admission or Visit

Enter the source using the one-digit code that represents the source of referral for admission.

Maternity Claims – Charges for the mother and ***level one NICU*** baby should be billed together, either on the same claim or at the same time. However, if the baby requires placement in a level two, three, or four Neonatal Intensive Care Unit (NICU) room (Revenue Code 172, 173, or 174, respectively), separate claims should be submitted for the mother and baby.

Note: For network hospitals with negotiated per diem/case rates, only one per diem/case rate will be paid for both the mother and baby, except when the baby requires placement in level two, three or four NICU or if the baby is in a level one NICU after the mother's discharge.

FL16 Discharge Hour

Enter the two-digit military time code to indicate the discharge hour.

FL17 Patient Discharge Status

Enter the two-digit status of the patient when service is ended.

FL18-FL28 Condition Codes

Enter the corresponding code in numerical order to describe any conditions or events that applied to the billing period.

FL29 Accident State

Not applicable

FL30 Reserved for Assignment by NUBC

Not applicable

FL31-FL34 Occurrence Code/Date

Enter occurrence code and associated dates defining specific events relating to the billing period.

FL35-FL36 Occurrence Span Code/From/Through

Enter codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.

FL37 **NOT USED**

Not applicable

FL38 **Responsible Party Name/Address**

Not applicable

FL39-FL41 **Value Code and Value Code Amount**

Enter the appropriate value code(s) and corresponding amount(s).

FL42 **Revenue Codes**

Enter valid Revenue Code for the services provided. Blue Shield will deny charges billed with invalid Revenue Codes.

Note: Certain billing scenarios may require Blue Shield to apply billed charges to Revenue Code 249. In some billing scenarios, Blue Shield may add Revenue Code 249 to identify combined or non-payable charges.

Note: If this data element is not provided, Blue Shield will consider this as an unclean claim and will return for correction.

FL43 **Revenue Code Description**

Enter a narrative description or standard abbreviation for each revenue code category.

FL44 **HCPCS/Accommodation Rates/HIPPS Rate Codes**

Enter valid HCPCS and appropriate modifier, rate or HIPPS Code for the services provided. Blue Shield encourages the use of modifiers in accordance with the National Uniform Billing Committee and the *California UB-04 Billing Procedures Manual*, as modifiers more accurately define the service(s) provided.

FL45 **Service Dates**

When billing for outpatient services and the "Statement Covers Period" (Form Locator 6) spans multiple dates, each service must be entered on a separate line with the actual date of service performed.

Multiple room and board individual dates of service are needed to process inpatient claims within Form Locator 45 or on the itemization.

Note: For network hospitals with negotiated per diems, additional payment for late discharges cannot be made under the terms of your contract.

Outpatient Charges and Multiple Inpatient Room & Board Charges must identify the date on each service line.

Note: If this data element is not provided, Blue Shield will consider this as an unclean claim and will return for correction.

FL46 Service Units

Enter the number of units, days, or visit where appropriate

Note: If this data element is not provided, Blue Shield will consider this as an unclean claim and will return for correction.

FL47 Total Charge

Enter the total charges for the number of charges billed.

FL48 Non-Covered Charges

Enter the total non-covered charges pertaining to the related revenue code in FL42.

FL49 Reserved for Assignment by NUBC

Not applicable

FL50-FL55 Other Payor Information

Enter the appropriate information if applicable as follows:

Box 50a-c: **Payor Name** – Enter the Primary payor name. Secondary/Tertiary information can be entered on the lines below.

Box 51a-c: Health Plan ID – Enter the Health Plan ID

Box 52a-c: **Release of Information** – Each payor line will have a separate Release of Information Certification Marker Box.

Box 53a-c: **Assignment of Benefits** – Each Payor line will have a separate Assignment of Benefits Marker Box.

Box 54a-c: **Prior Payments** – Enter any prior payment amounts received toward payment of the bill for the payor indicated in box 50.

Box 55a-c: **Estimated Amount Due** – Enter estimated amount due from each indicated payor in box 50.

FL56 **Billing Provider National Provider ID (NPI)**

Enter the National Provider ID for the billing provider.

FL57 **Other Provider ID**

Enter the Blue Shield Provider Identification Number (PIN).

FL58-FL65 **Insured's Information**

Box 58a-c: **Insured Name** – Enter the name of the policyholder for the primary/secondary/tertiary health plan as indicated in Box 50a-c

Box 59a-c: **Patient Relationship** – Identify the relationship of the patient to the primary insurance policyholder.

Box 60a-c: **Insured ID Number** – Enter the ID number for the Insured.

Box 61a-c: **Group Name** – Enter the Group Name of the Insured.

Box 62a-c: **Insured Group Number** – Enter the Group Number of the Insured.

Box 63a-c: Treatment Auth Codes – Enter the authorization or referral number assigned by the payor.

Enter the reference number that Blue Shield issues to track pre-admission information. For Access+ HMO and POS patients, enter both the Blue Shield tracking number and the reference number provided by the patient's IPA/medical group, if applicable. For emergency room visits, enter the name or license number of the authorizing physician, if the patient's primary care physician referred or approved the admission.

Box 64a-c: Document Control Number – Enter the Document Control Number assigned by the health plan

Box 65a-c: Employer Name – Not applicable

When more than one insurance carrier is involved, enter complete information regarding the primary, secondary, and other carriers and members. Indicate the other insurance carrier's name, address, and policy number in the "Remarks" section. Also include any payment information, if known. When Blue Shield is the secondary payor, attach a copy of the primary carrier's remittance advice or EOB. Also attach a copy of the other insurer's identification card, if available.

- If other insurance is indicated:
    - Line A – Enter the Primary Carrier information.
    - Line B - Enter the Secondary Carrier information.
    - Line C - Enter the Tertiary information.

- COB claims can be received electronically up to Tertiary. Blue Shield follows CMS guidelines. For facility inpatient claims, the COB is submitted at the claim level. For facility outpatient and professional claims, the COB is provided at the line level adjudication. For specific guidelines refer to Blue Shield's 837 Companion Guide found on Provider Connection at blueshieldca.com/provider.

FL66 Diagnosis and Procedure Code Qualifier

Enter the Primary diagnosis code and the qualifier code 0 for the tenth revision (ICD-10-CM)

FL67a-q Other Diagnosis and POA Indicator

Enter all the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Enter all the diagnosis codes using current ICD-10-CM Manual for accurate coding. The Present on Admission (POA) indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the *ICD-10-CM Official Guidelines for Coding & Reporting*) on all inpatient acute care facility claims.

Note: If this data element is not provided, Blue Shield will consider this as an unclean claim and will return for correction.

FL68 Reserved for Assignment by NUBC

Not applicable

FL69 Admitting Diagnosis

For inpatient hospital claims, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL70a-c Patient Reason for Visit Code

Enter the complete ICD-10-CM code describing the patient's reason for visit at the time of registration.

FL71 Prospective Payment System Code

Enter the appropriate DRG code

FL72a-c **External Cause of Injury Codes and POA Indicator**

Inpatient acute care facility claims must contain the External Cause of Injury (ECI) ICD-10-CM Code, along with the POA indicator, when an injury, poisoning, or adverse effect occurs during the medical treatment.

FL73 **Reserved for Assignment by NUBC**

Not applicable

FL74 **Principal Procedure Code and Date**

Enter the procedure code and date when a procedure was performed. Not used on outpatient claims.

FL74a-e **Other Procedure Codes and Dates**

Enter the procedure code and date when additional procedure was performed. Not used on outpatient claims

FL75 **Reserved for Assignment by NUBC**

Not applicable

FL76 **Attending Provider Name and Identifiers (including NPI)**

Enter the name and NPI of the attending physician.

FL77 **Operating Provider Name and Identifiers (including NPI)**

Enter the name and NPI of the individual with the primary responsibility for performing the surgical procedures.

FL78-FL79 **Other Provider Name and Identifiers (including NPI)**

Enter the name and NPI of the provider that corresponds to the indicated provider type on the claim.

Note: When submitting claims for a Blue Shield POS member who has self-referred enter the words “self-referral.”

FL80 **Genetic Testing Unit**

Not applicable

FL81 **Code-Code Field**

Enter the taxonomy code.

Reimbursement for Implants

Reimbursement for implants is based on a facility's contractual agreement in effect at the time services are rendered.

Blue Shield reimburses facilities for implants provided to Blue Shield members using a variety of payment terms, some of which include the cost of the implant.

For agreements under which implants are reimbursed on a cost basis with an administrative fee, the reimbursement is calculated as follows:

Reimbursement = Cost Implants +

((Cost of Implants/total invoice amount, exclusive of tax, shipping and handling costs) x (total tax + shipping + handling costs)) +$25

Example:

Invoice:	
Implants:	$ 3,000
Other items:	$10,000
Total invoiced tax:	$ 1,064
Total invoiced shipping and handling:	$ 300
Total invoice amount:	$14,364

Implant reimbursement = $3,000 + (($3,000/$13,000) x (300 + $1,064)) + $25 = $3,339.77

Reimbursement for Implants

This page intentionally left blank.

Table of Contents

Appendix for Section 5

This page intentionally left blank.

Table of Contents

Section 1

Introduction to the BlueCard® Program

As a contracted provider of Blue Shield of California (Blue Shield), you may render services to patients who are insured by other states' Blue plans, and who travel in or live within California.

This section describes the advantages of the BlueCard Program and provides information to make filing claims easy. You will find helpful information about:

- Identifying out-of-state Blue plan members
- Verifying eligibility and benefits
- Locating other states' Blue plan medical policies and pre-certification requirements
- Requesting and obtaining authorizations
- Submitting BlueCard claims and requesting medical records
- Accessing BlueCard resources and contact information

The BlueCard® Program

Definition of the BlueCard Program

BlueCard® is a national program that enables Blue Cross and Blue Shield (BCBS) plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield plan's service area. The program links participating healthcare providers with all the independent Blue Cross and Blue Shield plans across the country through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

BlueCard Program Advantages to Providers

The program allows you to conveniently submit claims for patients from out-of-state Blue plans, either domestic or international, directly to Blue Shield.

Blue Shield is your primary contact for BlueCard claim submission, claims processing, and provider inquiries.

Blue Shield, a mission-driven and nonprofit health plan established in 1939, continues to experience growth in other state Blue plan membership because of our partnership with you. That is why we are committed to meeting your needs and expectations and creating a sustainably affordable healthcare system that's worthy of our family and friends. In doing so, your patients will have a positive experience with each visit.

Services Processed Through the BlueCard Program

Claims for all inpatient, outpatient and professional services generated for other state Blue plan members are processed through the BlueCard Program.

Products Included in the BlueCard Program

A variety of products and claim types are eligible to be delivered via BlueCard, however not all Blue plans offer all the products listed below to their members.

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization), including Blue High Performance Network℠ (Blue HPN℠)
- POS (Point of Service)
- HMO (Health Maintenance Organization)
    - HMO claims are eligible to be processed under the BlueCard Program or through the Away From Home Care Program.
- Blue Cross Blue Shield Global® Core
- GeoBlue Expat claims
- Standalone vision
- Standalone prescription drugs

Note: Standalone vision and standalone self-administered prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.

Note: Definitions of the above products are available in the Glossary of Terms section of this manual.

Products Excluded from the BlueCard Program

The following claims are excluded from the BlueCard Program:

- Stand-alone dental
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)
- Vision claims delivered through an intermediary model (using a vendor)
- Federal Employee Program (FEP) member claims
- Medicaid and SCHIP that is part of the Medicaid program
- Medicare Advantage*

*Medicare Advantage is a separate program from BlueCard and delivered through its own centrally administered platform. However, since you might see members of other Blue plans who have Medicare Advantage coverage, there is a section on Medicare Advantage claims processing in this manual.

Section 2

How Does the BlueCard Program Work?

How to Identify Members

Member ID Cards

When members of other state Blue plans arrive at your office or facility, be sure to ask them for their current Blue plan membership identification card.

The main identifier for other state Blue plan members is the three-character prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo, for eligible Traditional, HMO, POS, or indemnity members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
- A BlueHPN in a suitcase logo with the Blue High Performance Network℠ (BlueHPN℠) name in the upper right or lower left corner, for BlueHPN EPO members

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to Blue Shield's PPO provider contract. Please note that EPO products may have limited benefits out-of-area. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

How to Identify Members *(cont'd.)*

Member ID Cards *(cont'd.)*

For members having traditional or HMO coverage, you will be reimbursed according to Blue Shield's traditional provider contract. For members who have POS coverage, you will be reimbursed according to Blue Shield's POS provider contract, if you participate in the BlueCard POS voluntary program or you will be reimbursed according to Blue Shield's Traditional provider contract, if you don't participate in the BlueCard POS voluntary program.

The Blue HPN EPO product includes a BlueHPN in a suitcase logo on the ID card. Members must obtain services from BlueHPN providers to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for covered services in accordance with your contract with Blue Shield of California. If you are not a BlueHPN provider, it is important to note that benefits for services incurred with non-BLUEHPN providers are limited to emergent care within BlueHPN product areas, and to urgent and emergent care outside of BlueHPN product areas. For these limited benefits, if you are a PPO provider, you will be reimbursed according to Blue Shield of California PPO provider contract, just like you are for other EPO products.

Some Blue ID cards do not have any suitcase logo on them. Those ID cards include Medicaid, State Children's Health Insurance Programs (SCHIP) if administered as part of State's Medicaid, and Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products. While Blue Shield routes these claims for out-of-area members to the member's Blue plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's Blue Plan via the established electronic crossover process.

How to Identify Members *(cont'd.)*

Member ID Cards *(cont'd.)*

Important facts concerning member IDs:

- A correct member ID includes the three-character prefix (first three positions) and all subsequent characters, up to a total of 17 positions. This means that you may see cards with IDs between 6 and 14 numbers or letters following the prefix.
- Do not add or delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- The three-character prefix is critical for the electronic routing of specific HIPAA-compliant transactions to the appropriate Blue plan.
- Members who are part of the Federal Employee Program (FEP) will have the letter "R" in front of their member ID. FEP claims are not processed by the BlueCard Program. Providers are required to submit claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Instead, FEP professional claims that require medical records should be sent to the FEP Claims Unit at P.O. Box 272510, Chico, CA 95927-2510.
- Note that most out-of-state Blue plan member ID cards have plan names that begin with "Blue Cross Blue Shield" brand names and identifies the state where members receive coverage. However, some Blue plans have unique plan names that do not begin with "Blue Cross Blue Shield" branding and do not identify the state where the member receives coverage. Nevertheless, you can submit BlueCard claims to Blue Shield for members whose ID cards have unique Blue plan names.

Examples of member IDs:

How to Identify Members *(cont'd.)*

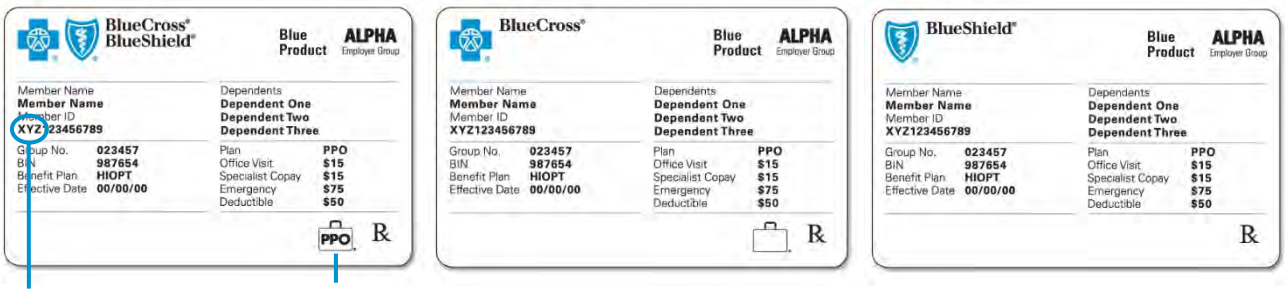
Three-Character Prefix

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue plan to which the member belongs. It is critical for confirming a patient's membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card and pass this key information to your billing staff. Do not make up prefixes.

As a provider serving other state Blue plan members, you may find the following tips helpful:

- Ask the member for his or her most current Blue ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in your patient's file.
- Member IDs must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID.



The three-character prefix.

The "PPO in a suitcase" logo may appear anywhere on the card, but in this example, it appears in the lower right corner of the I.D. card.

Note: ID card samples are not the actual depiction of cards; they show the general look and feel for the brand guidelines from the Association.

How to Identify Members *(cont'd.)*

BlueCard PPO Basic ID Cards

Currently, Blue Shield does not offer a BlueCard PPO Basic network to local Blue Shield members. However, you may see patients with BlueCard PPO Basic coverage by another state Blue Plan. Providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California.

In addition to patients who have traditional Blue PPO, HMO, POS, or other coverage, you may now see patients who have a BlueCard PPO Basic product.

When you see the "PPOB in a suitcase" logo on the front of the member's ID card, it means the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

Sample ID Card

How to Identify Members *(cont'd.)*

How to Identify BlueHPN Members

The Blue High Performance Network℠ (BlueHPN℠) is a new network that is available to members that live in key metropolitan areas. BlueHPN members must access BlueHPN providers in order to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for services provided to BlueHPN members according to your contract with Blue Shield of California. If you are not a BlueHPN provider, it is important to note that benefits for services incurred with non-BlueHPN providers are limited to emergent care within BlueHPN product areas, and to urgent and emergent care outside of BlueHPN product areas.

You can recognize BlueHPN members by the following:

- The Blue High Performance Network name on the front of the member ID card
- The BlueHPN in a suitcase logo in the bottom right-hand corner of the member ID card

Those BlueHPN products offered may include fully-insured and self-insured Blue plan members. Language regarding benefit limitations is also included on the back of the BlueHPN EPO member ID card. For these limited benefits, if you are not a BlueHPN provider but are a PPO provider, you will be reimbursed according to Blue Shield of California PPO provider contract, just like you are for other EPO products.

Sample ID Cards

How to Identify Members *(cont'd.)*

How to Identify International Blue Plan Members

Occasionally, you may see identification cards that are from members of International Licensees or that are for international-based products. Currently those Licensees include Blue Cross Blue Shield of the U.S. Virgin Islands, BlueCross & BlueShield of Uruguay, Blue Cross and Blue Shield of Panama, and Blue Cross Blue Shield of Costa Rica, and those products include those provided through Blue Shield Global Core and the Blue Cross Blue Shield Global™ portfolio. Always check with Blue Shield of California as the list of International Licensees and products may change. ID cards from these Licensees and for these products will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic Blue plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and electronically submit their claims to Blue Shield of California. See below for sample ID cards for international members and products.

Sample ID Card


BlueCross & BlueShield de Uruguay

MEMBER NAME
Member Name
MEMBER ID
XYZ 0123456789

Plan PPO
GROUP URU038
BC/BS Plan Codes: 154/654

Plan
1400
RPA PREMIUM
Expiration Date: May. 31, 2011

CREDENCIAL PARA USO EXCLUSIVO FUERA DE URUGUAY

PPO


BlueCross & BlueShield de Uruguay

www.bcbsu.com.uy

Clientes: Por beneficios consulte su contrato. La posesión de esta tarjeta no garantiza la elegibilidad de los beneficios.

Proveedores en Uruguay: Para verificar elegibilidad y beneficios, por favor llamar a nuestras oficinas. Dirija facturas por servicios médicos a nuestra dirección.

Providers in the United States: To verify membership eligibility, please call Eligibility line. Providers should file all claims to the local BlueCross and/or BlueShield Plan in whose Service Area the member received services.

Uruguay
Atención al Cliente: (598-2) 707-7575

United States (E.E.U.U.)
Customer Service: (598-2) 707-7575
Provider Finder: 1-800-810-2583
Eligibility: 1-800-676-2583

BlueCross & BlueShield de Uruguay
Lord Ponsonby 2456
11600 Montevideo, Uruguay
An Independent Licensee of the BlueCross and BlueShield Association.

How to Identify Members *(cont'd.)*

How to Identify International Blue Plan Members *(cont'd.)*

Illustration A - GeoBlue

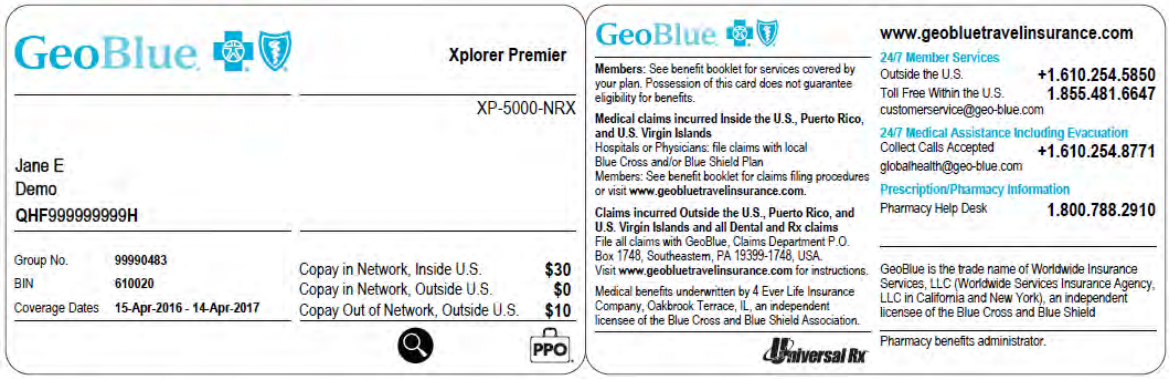


Illustration B – Blue Cross Blue Shield Global portfolio

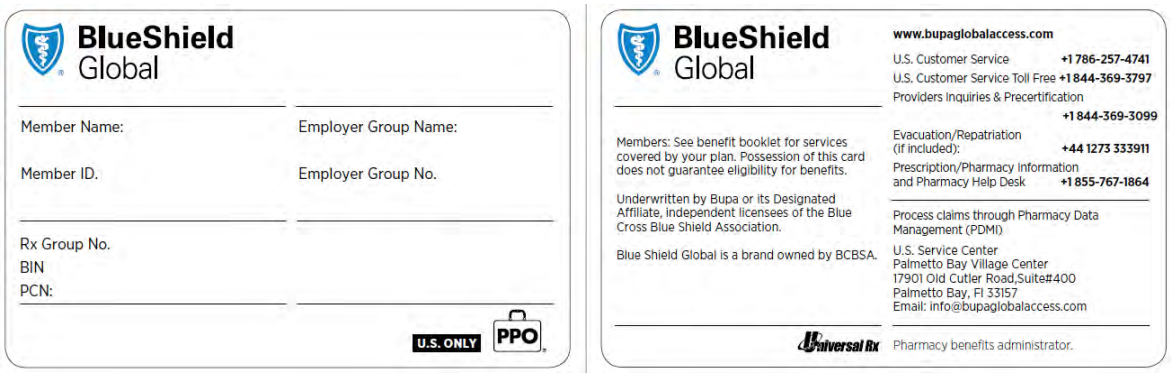
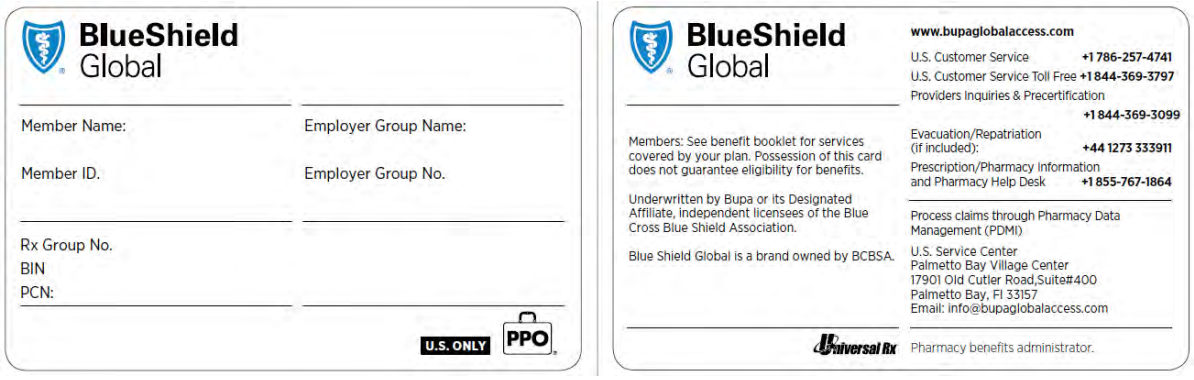


Illustration C – Shield-only ID Card

Note: In certain territories, including Hong Kong and the United Arab Emirates, Blue Cross branded products are not available. The ID cards of members in these territories will display the Blue Shield Global logo (see example below):



How to Identify Members *(cont'd.)*

How to Identify International Blue Plan Members *(cont'd.)*

Canadian ID Cards

Note: The Canadian Association of Blue Cross plans and its member plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member plans in the United States.

You may occasionally see ID cards for people who are covered by a Canadian Blue Cross plan. Claims for Canadian Blue Cross plan members are not processed through the BlueCard® Program.

Please follow the instructions of the Blue Cross plans in Canada and those, if any, on the ID cards for servicing their members. The Blue Cross plans in Canada are:

Alberta Blue Cross	Ontario Blue Cross	Quebec Blue Cross
Manitoba Blue Cross	Pacific Blue Cross	Saskatchewan Blue Cross
Medavie Blue Cross		

Source: www.bluecross.ca/en/contact.html

How to Identify Members *(cont'd.)*

Consumer Directed Health Care and Healthcare Debit Cards

Consumer Directed Health Care (CDHC) is a term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. Health plans that offer CDHC plans provide the member with additional information to make an informed and appropriate healthcare decision using member support tools, provider and network information, and financial incentives. Members who have CDHC plans often carry healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangements (HRA), Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA). All three are types of tax favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some cards are "stand-alone" debit cards to cover out-of-pocket costs, while others also serve as a member ID card with the member ID number. These debit cards can help you simplify your administration process and can potentially help:

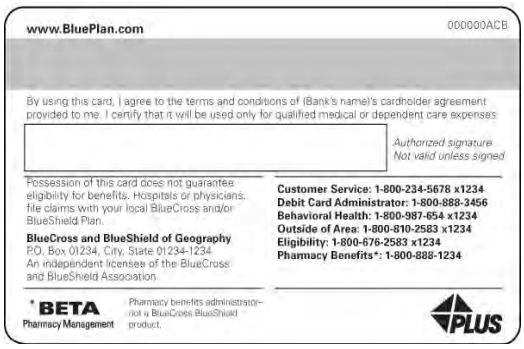
- Reduce bad debt
- Reduce paperwork for billing statements
- Minimize bookkeeping and patient-account functions for handling cash and checks
- Avoid unnecessary claim payment delays

In some cases, the card will have the nationally recognized Blue logos, along with the logo from a major debit card organization such as MasterCard® or Visa®.

Sample of Stand-Alone Healthcare Debit Card

How to Identify Members *(cont'd.)*

Consumer Directed Health Care and Healthcare Debit Cards *(cont'd.)*



The cards include a magnetic strip so providers can swipe the card at the point of service to collect the member copayment. With the healthcare debit cards members can pay for copayments and other out-of-pocket expenses by swiping the card though any provider's debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

Combining a healthcare ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone to process payments. In addition, members are more likely to carry their *current* ID cards, because of the payment capabilities. If your office currently accepts credit card payments, there is no additional cost or equipment necessary beyond what you already pay to swipe other signature debit cards.

Limited Benefit Products

Another new product and benefit type in the healthcare market is the limited benefit products for Blue plan patients whose annual benefits are limited to $50,000 or less.

Currently, Blue Shield does not offer such limited benefit plans to our members. However, you may see patients with limited benefits who are covered by an out-of-state Blue plan.

How to recognize members with limited benefits products

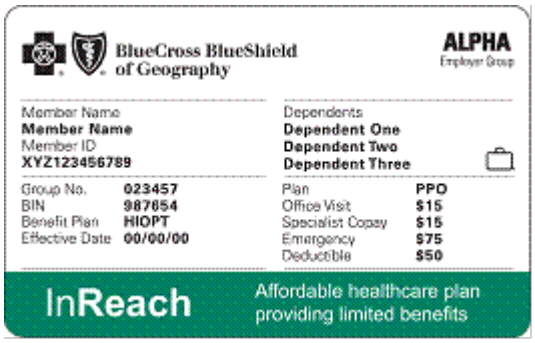
Members with Blue limited benefits coverage (that is, annual benefits limited to $50,000 or less) carry ID cards that may have one or more of the following indicators:

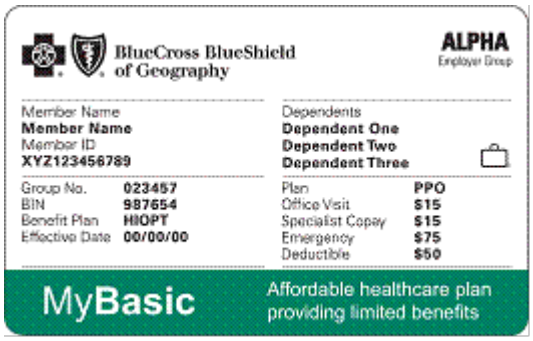
- Product name will be listed such as **InReach** or **MyBasic**
- A **green stripe** at the bottom of the card
- A statement either on the front or the back of the ID card stating this is a limited benefits product
- A **black cross and/or shield** to help differentiate it from other identification cards

How to Identify Members *(cont'd.)*

Limited Benefit Products *(cont'd.)*

These ID cards may look like this:





How to find out if the patient has limited benefit coverage

In addition to obtaining a copy of the patient's ID card and regardless of the benefit product type, we recommend that you verify patient's benefits and eligibility and collect any patient liability or copayment only. You may do so electronically by submitting an eligibility inquiry to Blue Shield at blueshieldca.com/provider or by calling BlueCard® *Eligibility* at (800) 676-BLUE (2583).

You will receive the patient's accumulated benefits to help you understand the remaining benefits left for the member. If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability he or she might have.

What to do if the patient's benefits are exhausted before the end of their treatment

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatment might be member's liability. We recommend that you inform patients of any potential liability they might have as soon as possible.

How to Identify Members *(cont'd.)*

Helpful Tips *(cont'd.)*

- Check eligibility and benefits electronically by logging onto Provider Connection at blueshieldca.com/provider or by calling (800) 676-BLUE (2583) and providing the three-character prefix. Online eligibility and benefits results for out-of-state Blue plan members include the following elements:
    - Other payor information if the member has other insurance
    - An authorization indicator if authorization or referral is required
    - Pre-existing condition information, if applicable
    - Accumulated year-to-date deductible amounts
    - Accumulated year-to-date out-of-pocket costs
    - Accumulated year-to-date benefit maximum amounts
    - Accumulated year-to-date individual lifetime maximum amounts
- Please do not use the debit card to process full payment up front. If you have any questions about the member's benefits, log onto blueshieldca.com/provider to perform a BlueCard eligibility and benefits search, or call (800) 676-BLUE (2583). For questions about the debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

Coverage and Eligibility Verification

Provider Connection, our provider website at blueshieldca.com/provider, gives you direct access to current, reliable information for other state Blue plan members' eligibility, benefits, claims mailing address, and share of cost. You can receive more detailed benefit information when searching for other state Blue plan members' benefits online. Submit an online inquiry about certain benefits you would like more information on, and the benefit information will be returned to you onscreen or sent to the Provider Connection Message Center.

You can also verify other state Blue plan member eligibility, benefits coverage and share of cost information by calling BlueCard *Eligibility®* at (800) 676-BLUE (2583). This automated Voice Response Unit (VRU) will prompt you to provide the three-character prefix and will route your call to the member's Blue plan.

Keep in mind that Blue plans are located throughout the country and may operate on a different time zone than Blue Shield. You may be transferred to a voice response system linked to customer enrollment and benefits.

The BlueCard *Eligibility®* line is for eligibility, benefit, and pre-certification/referral authorization inquiries only. It should not be used for determining where to submit your BlueCard claims or for claim status. See the Claim Filing section in this manual for claim filing information.

Eligibility and Benefits for BlueHPN EPO Members

BlueHPN EPO members will be identified as such within the eligibility and benefits result response. If you are a Blue Shield of California contracted provider within BlueHPN network, submit your claim to Blue Shield. If you are not a contracted BlueHPN provider with Blue Shield of California, you should be aware that the only services that are covered for BlueHPN EPO members are urgent and emergent care outside of BlueHPN product areas. Benefits are determined by Blue plan the member is insured with.

Coordination of Benefits (COB) Information on Blue Plan Members

Coordination of Benefits (COB) refers to how the Blue System ensures that Blue plan members receive full benefits and prevent double payment for services when a Blue plan member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Blue plan member benefit structures vary and state requirements around the collection of other insurance information differ across the country. To reduce the number of BlueCard claims being denied for lack of COB information, processing standard requirements are in place to limit instances when Blue plans can reject claims for COB investigations.

When you see Blue plan patients who you are aware might have other health insurance coverage (i.e., Medicare, other Blue plan), please keep in mind the following:

- If Blue Shield of California or any other Blue plan is the primary payor, submit the other carrier's name and address with the claim to Blue Shield of California. If you do not include the COB information with the claim, the member's Blue plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.
- If another non-Blue health plan is primary and Blue Shield of California or any other Blue plan is secondary, submit the claim to Blue Shield of California only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue plan will have to investigate the claim, which may result in a payment delay or post-payment adjustment.

Coordination of Benefits (COB) Information on Blue Plan Members *(cont'd.)*

Carefully review the payment information from all payors involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the Blue Shield of California remittance advice as "patient liability" might be different from the actual amount the patient owes you, due to the combination of the primary insurer payment and your negotiated amount with Blue Shield of California.

If you have any questions regarding COB claims processing or payments in relation to Blue plan members, please contact the BlueCard Program Customer Service Unit at (800) 622-0632.

Your involvement is needed to assist in collecting other insurance information from Blue plan members. To avoid claim rejections due to lack of COB information, use the COB Questionnaire to collect information from any Blue plan member who has insurance coverage in addition to his/her out-of-state Blue plan coverage.

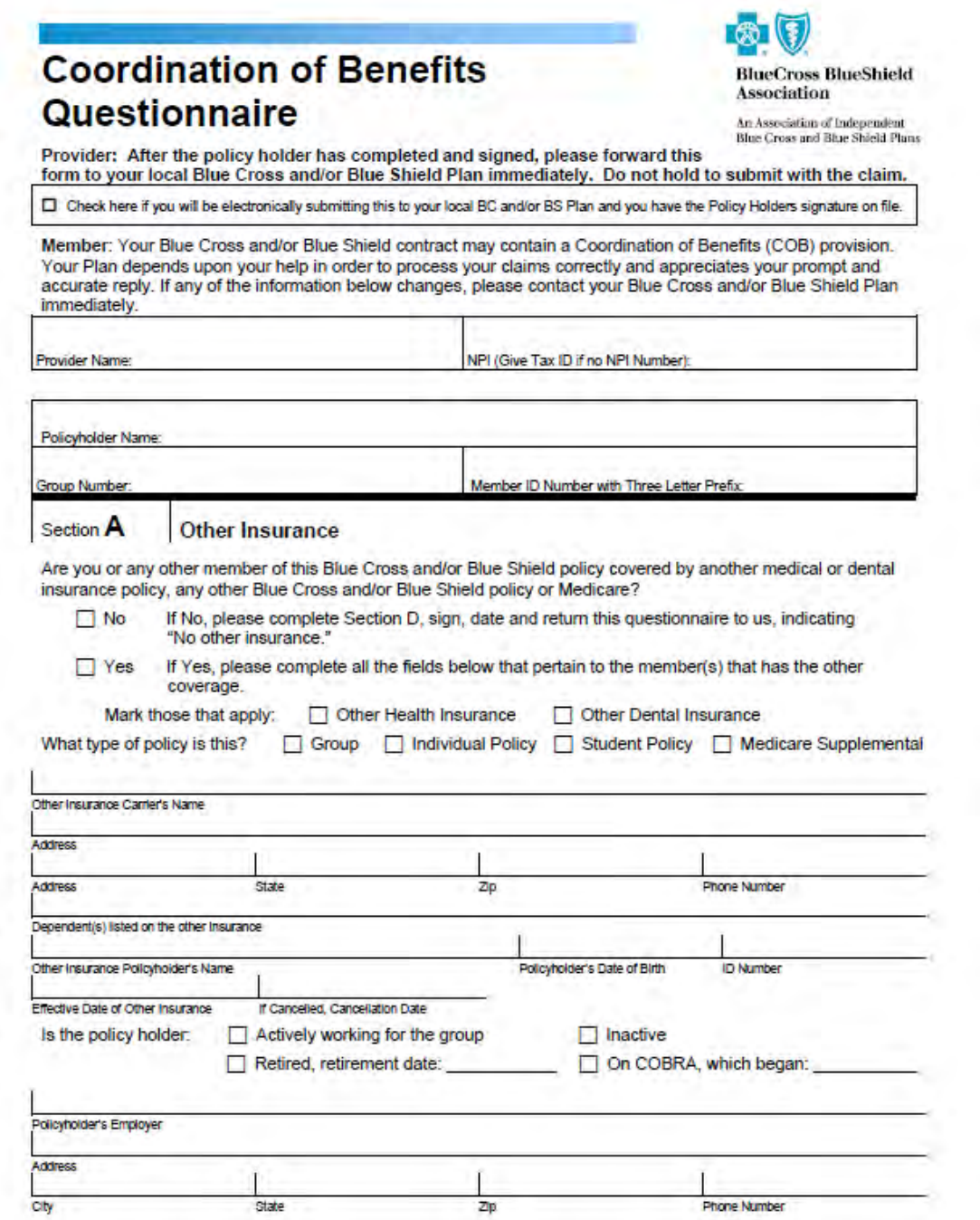
When other state Blue plan members state they have other insurance coverage in addition to their out-of-state Blue plan coverage, please perform one of the following:

1. During the patient's visit, request the patient complete and return the COB Questionnaire to you, then mail the completed form on behalf of the patient to Blue Shield to:

   Blue Shield of California, BlueCard Program, P.O. Box 272630, Chico, CA 95927-2630.
2. During the patient's visit, give the patient a COB Questionnaire with instructions to complete and submit the form to his or her other state Blue plan as soon as possible.

Refer to the COB Questionnaire on the following pages or on www.blueshieldca.com/provider under *Guidelines & resources,* then *Forms,* then *Patient care forms.*

Coordination of Benefits Questionnaire



Coordination of Benefits Questionnaire

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Provider: After the policy holder has completed and signed, please forward this form to your local Blue Cross and/or Blue Shield Plan immediately. Do not hold to submit with the claim.

☐ Check here if you will be electronically submitting this to your local BC and/or BS Plan and you have the Policy Holders signature on file.

Member: Your Blue Cross and/or Blue Shield contract may contain a Coordination of Benefits (COB) provision. Your Plan depends upon your help in order to process your claims correctly and appreciates your prompt and accurate reply. If any of the information below changes, please contact your Blue Cross and/or Blue Shield Plan immediately.

Provider Name:	NPI (Give Tax ID if no NPI Number):

Policyholder Name:	
Group Number:	Member ID Number with Three Letter Prefix:

Section **A** | **Other Insurance**

Are you or any other member of this Blue Cross and/or Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross and/or Blue Shield policy or Medicare?

☐ No If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

☐ Yes If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark those that apply: ☐ Other Health Insurance ☐ Other Dental Insurance

What type of policy is this? ☐ Group ☐ Individual Policy ☐ Student Policy ☐ Medicare Supplemental

Other Insurance Carrier's Name

Address

Address | State | Zip | Phone Number

Dependent(s) listed on the other Insurance

Other Insurance Policyholder's Name | Policyholder's Date of Birth | ID Number

Effective Date of Other Insurance | If Cancelled, Cancellation Date

Is the policy holder: ☐ Actively working for the group ☐ Inactive

☐ Retired, retirement date: _____ ☐ On COBRA, which began: _____

Policyholder's Employer

Address

City | State | Zip | Phone Number

Section B Medicare Information

Do the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No

Name of person(s) with Medicare

Medicare Number, including alpha character(s)

Effective Date of Medicare Part A: _____ Effective date of Medicare Part B: _____

Medicare Entitlement: ☐ Yes ☐ Disability* ☐ Yes ☐ End Stage Renal Disease (ESRD)*

If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability:

1st Date of Dialysis for ESRD:

Was ESRD started in a facility? ☐ Yes ☐ No

Was ESRD started as Self Dialysis of Home Dialysis? ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If yes, please provide the date of the transplant: _____

Section C Court Order Information

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ Yes ☐ No

List the name(s) of the dependent(s) that this applies to.

If yes, who is the person(s) listed to maintain health coverage?

What is the relation to the child(ren)? | Who has custody of the child(ren) more than 50% of the time?

Documentation of the court order may be requested from your Blue Cross and/or Blue Shield Plan

Section D Names of Dependent(s) on Blue Cross and/or Blue Shield Policy

Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)

Policy Holder Signature **Date**

Other State Blue Plan Members' Medical Policies and Pre-Certification/Prior Authorization Requirements

On Provider Connection, our provider website**,** you can now find information to help you treat other state Blue plan members. You can view medical policies and general pre-certification/prior authorization requirements applicable to other state Blue plan members, along with contact information to initiate the pre-certification/prior authorization process.

To access the medical policy and pre-certification/prior authorization requirements, follow the steps below:

1. Log onto www.blueshieldca.com/provider.

2. Click on the *Pre-service review for out-of-area members* link within the *Authorizations* section of Provider Connection.

3. Enter the other state Blue plan member's three-character prefix, select either the medical policy or the prior authorization button, and then click on "Search."

This online functionality gives providers easy access to information and provides a valuable supplement to the information you currently receive when verifying other state Blue plan members' benefits, eligibility and share of costs, directly from the member's Blue plan.

Prior Authorization

Prior authorization of medical services for other state Blue plan members is provided by the member's Blue plan. Providers can request authorization for other state Blue plan member online by using the Electronic Provider Access (EPA) tool. The EPA tool will enable you to use Blue Shield's provider website to gain secured access to another Blue plan's provider website to request authorization.

To access the EPA tool, log onto Provider Connection at blueshieldca.com/provider, click on the *Pre-service review for out-of-area members* link within the *Authorizations* section. Choose from the available options to assist in obtaining the necessary information:

- Medical Policy Information – Select this option to obtain medical policy for a service.

- Prior Authorization Information – Select this option to determine if pre-service and pre-authorization is required for a service.

- Electronic Provider Access – Select this option to submit a pre-certification and prior authorization request.

Prior Authorization *(cont'd.)*

Providers will need the member's three-character prefix to complete each search. The prefix is the first three characters that precede the member identification number.

By entering a valid prefix, you will then be automatically routed to the member's Blue plan provider portal to begin an authorization request. Please note that each Blue plan's website is customized to their authorization services they offer.

Providers can also contact the member's Blue plan by calling the designated telephone number of the Health Care Services department located on the back of the member's ID card.

The member's Blue plan may contact you directly related to clinical information or to request medical records prior to treatment or for concurrent review or chronic condition management for a specific member.

> *Note:* Failure to obtain required prior authorization or admission review may result in partial or total benefit denial and/or greater out-of-pocket expenses for Blue plan members. However, obtaining approval is not a guarantee of payment. Participating providers are responsible for obtaining pre-service review/preauthorization for inpatient facility services. In addition, members are held harmless when pre-service review/ preauthorization is required and not obtained for inpatient facility services.

Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/authorization for outpatient services from their Blue plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (see section entitled Provider Financial Responsibility). In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

General information on pre-certification/preauthorization information can be found by clicking on the *Pre-service review for out-of-area members* within the *Authorization* section of blueshieldca.com/provider.

When obtaining pre-certification/preauthorization, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to communicate immediately with a member's Blue Plan if any changes in treatment or setting occurs to ensure an existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for additional days may result in claims processing delays and potential payment denials.

When the length of an inpatient hospital stay extends past the previously-approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claim processing delays and potential payment denials.

Electronic Provider Access

Electronic Provider Access (EPA) gives providers the ability to access other state Blue plan provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization, and prior approval, amongst other pre-claim processes. EPA enables providers to use their local Blue plan provider portal to gain access to other state Blue plan member's provider portal, through a secure routing mechanism. Once in the Blue plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Blue plan's local providers.

The availability of EPA varies depending on the capabilities of each Blue plan. Some Blue plans have electronic pre-service review for many services, while others do not. The following describes how to use EPA and what to expect when attempting to contact other Blue plans.

Using the EPA Tool

Log onto blueshieldca.com/provider, click on *Pre-service review for out-of-area members* link within the *Authorizations* section. Choose the *Electronic Provider Access* option. You will be asked to enter the three-character prefix from the member's ID card, which is the first three characters that precede the member subscriber identification number. The NPI and location of requesting provider are also required, as is whether or not you are a Blue Shield of California contracted provider. Once those fields have been filled out, click the "Submit" button.

After submitting, you are routed to the member's Blue plan EPA landing page. This page welcomes you to the other state Blue plan's portal and indicates that you have left Blue Shield of California's provider portal. The landing page allows you to connect to the available electronic pre-service review processes. Because the screens and functionality of other state Blue plan pre-service review processes vary widely, other Blue plans may include instructional documents or e-learning tools on their Blue plan landing page to provide instruction on how to conduct an electronic pre-service review. The page may also include instructions for conducting pre-service review for services where the electronic function is not available.

The other state Blue plan landing page looks similar across the Blue plan system but will be customized to the particular Blue plan based on the electronic pre-service review services they offer.

Provider Financial Responsibility for Pre-Service Review for Blue Plan Members

Blue Shield's participating providers are responsible for obtaining pre-service review for inpatient facility services for BlueCard members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers must also:

- Notify the member's Blue plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member's Blue plan for pre-service review or for a change or modification of the pre-service review will result in claim processing delays and potential payment denials for inpatient facility services. The Blue plan member must be held harmless and cannot be balance-billed if pre-service review has not occurred.*

Pre-service review contact information for a member's Blue plan is provided on the member's identification card. Pre-service review requirements can also be determined by:

- Using the Electronic Provider Access (EPA) tool available at Blue Shield's provider portal at www.blueshieldca.com/provider.
- Submitting an ANSI 278 electronic transaction to Blue Shield.
- Calling the BlueCard Eligibility toll-free phone number at (800) 676-BLUE.

Services that deny as not medically necessary remain the member's liability.

If you have any questions on Provider Financial Responsibility or general questions, please call Blue Shield at (800) 622-0632.

**Unless the member signed a written consent to be billed prior to rendering service.*

Medical Records Requests and Processing

Blue Shield is dedicated to achieving a seamless delivery of medical records requests and processing for other state Blue plan members and the providers who serve them.

Medical records related to your other state Blue plan patients may be requested as part of the pre-claim experience, as part of a concurrent review or as part of the BlueCard claim appeal process. It is Blue Shield's responsibility to obtain medical records from our providers at the request of the member's Blue plan. However, in pre-claim situations, the member's Blue plan may directly contact you to request medical records if the member's Blue plan needs the records to make a determination as part of the prior authorization or pre-certification process or in situations that are deemed as an urgent medical need.

Blue Shield performs the following steps to ensure delivery of medical record requests and processing:

- When receiving a medical records request from the member's Blue plan, we verify whether or not the provider has already submitted the records.
- When a member's Blue plan requests medical records, we send the request to our providers within two business days of receipt of the out-of-state Blue plan's request.
- When requesting medical records from a provider, we strive to send concise and specific details to fulfill the request.
- We send medical record requests to the address and department indicated in your provider demographics profile.
- When providers respond to requests and submit medical records to us, to help us ensure that all records are sent electronically to the member's Blue plan within three business days of their receipt, please include the medical records request letter with all supporting documentation.
- We follow up with the member's Blue plan to ensure that records are reviewed and adjusted in a timely manner.
- We maintain copies or images of all medical records received from providers.

To make the medical records process more efficient, please respond to medical record requests within 10 days of the request.

Section 3

Claim Filing

Processing BlueCard Claims

Blue Shield processes BlueCard claims for inpatient, outpatient, professional, and ancillary* services rendered to other state Blue plan members. Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character prefix. Claims with incorrect or missing prefixes and member identification numbers cannot be filed correctly. Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Please indicate the member's subscriber ID number, including the three-character prefix, on each electronically submitted claim. If you have any questions about the process or require additional information on electronic claim submission, contact our EDI Help Desk by calling (800) 480-1221.

You may now submit claims online through clearinghouse vendor Office Ally. Once at the EDI clearinghouse's website, you will have the option to review the claim submission services offered. To visit Office Ally and for detailed information about electronic submissions, go to Provider Connection at blueshieldca.com/provider, click on *Claims,* then click on the *Submit claims for free* box in the claims tool area.

Mail hard-copy BlueCard claims that require medical records to:

Blue Shield of California
BlueCard Program
P. O. Box 272630
Chico, CA 95927-2630

BlueCard Claim Tips

After the member of another Blue plan receives services from you, you should submit the claim to Blue Shield of California. We will work with the member's Blue plan to process the claim and the member's Blue plan will send an explanation of benefit (EOB) to the member. We will send you an explanation of payment or remittance advice and applicable payment to you under the terms of our contract with you and based on the member's benefits and coverage.

Following these helpful tips will improve your claim experience:

- Ask members for their current member ID cards and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including the three-character prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at www.blueshieldca.com/provider or by calling
(800) 676-BLUE (2583). Be sure to provide the member's three-character prefix.
- Verify the member's cost sharing amount before processing payment. Please do not process full payment upfront as Blue plan members are responsible for their share of cost, deductible, co-insurance, and non-covered services.
- Indicate any payment you collected from the patient on the claim.
- Submit BlueCard claims to Blue Shield of California. Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Be sure to include the member's complete subscriber identification number when you submit the claim. This includes the three-character prefix. Submit claims with only valid prefixes; claims with incorrect or missing prefixes and member identification numbers cannot be processed.
- Reduce claim adjustments by double-checking to ensure you have indicated the correct provider Tax ID Number (TIN), Provider Identification Number (PIN) and/or the National Provider Identifier (NPI) number.
- In cases where there is more than one payor and a Blue plan is a primary payor, submit Other Party Liability (OPL) information with the BlueCard claim. Upon receipt, Blue Shield of California will electronically route the claim to the member's Blue plan.

BlueCard Claim Tips *(cont'd.)*

- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, slows down the claims payment process and creates confusion for the member. Go to Provider Connection at blueshieldca.com/provider for direct access, 24 hours a day, seven days a week, for current, reliable information on BlueCard claims, payment status and claim reporting tools.
- To avoid denials as duplicates when submitting corrected BlueCard claims, file them after the original claim has finalized. After the original claim is finalized, you may submit the corrected claim electronically by identifying the claim as Type of Bill (XX7).
- If medical records are requested, send them to the claims address along with the medical request letter you received from Blue Shield.
- Check claims status by contacting Blue Shield of California at blueshieldca.com/provider, contact Blue Shield's dedicated BlueCard Customer Service Unit at (800) 622-0632, or submit an electronic HIPAA 276 transaction to Blue Shield of California.
- You can reduce claim rejects by matching the admit date in Box 12 with the date in Box 6 on the UB 04 claim form. These dates must match for claims processing.
- If you're submitting implant reimbursements with bulk invoices, clearly indicate which implants were used in the service for which you are billing. Submit the manufacturer's invoice instead of the purchase order, unless your contract clearly states that a purchase order may be submitted.
- For implant claims, submit the implant invoice on the first submission with the claim. This will enable Blue Shield to process your claim in full on the first submission rather than processing surgery charges first and then adjusting the claim for the implant charges later.

Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. However, if you mail hard-copy BlueCard claims that require medical records, please consider these paper claim tips:

- Always use an original UB 04 claim form, not a photocopy. Duplicated claim forms often cannot be scanned and can create processing delays and accuracy risks.
- When typing or writing on the UB 04 claim form, avoid typing or writing over the titles of claim boxes.
- You may apply a stamp on the paper claims with clear messages; however, do not cover up key information with the stamp. Attaching a cover sheet to the claim is an acceptable alternative to applying a stamp to the claim form.

BlueCard Claim Tips *(cont'd.)*

- Please type or write in a font size that is large enough so that your message can be clearly read.
- BlueCard hospital exception claims, provider correspondence, and all other BlueCard paper claims are sent to:

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico, CA 95927-2630

After you have submitted BlueCard claims to Blue Shield, you may obtain status and verify payment information on your BlueCard claims by accessing the *Claims* section on our website at blueshieldca.com/provider. Use this tool as your primary resource for requesting and receiving details and status of BlueCard claim.

If you have remaining questions about your BlueCard claims after accessing the *Claims* section on our website, access additional information within Resources section of BlueCard Program, or contact Blue Shield's dedicated BlueCard Customer Service Unit at (800) 622-0632 or access our online Chat feature at www.blueshieldca.com/provider.

Submitting BlueCard Claims

Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. The following are tips on how to submit claims:

1. Access our Claims Routing Tool on Provider Connection at www.blueshieldca.com/provider by clicking on the *Claims Routing Tool* link within the *Claims* section. Simply enter the member's three-character prefix and date of service to instantly learn where to send the BlueCard claim.

2. Note the claim address and patient benefit information added to the online verification of Eligibility and Benefits search results returned by blueshieldca.com/provider. You will find the information you need to correctly send BlueCard claims, as well as local Blue Shield commercial and FEP claims. On the right-hand side of your search results, refer to the appropriate payor information, claims mailing address for medical record attachments, claims unit's toll-free telephone number and member eligibility toll-free telephone number.

3. If and for so long as the hospital or facility is not contracted with another licensee of the Blue Cross Blue Shield Association in the State of California, providers shall submit to Blue Shield for processing all claims for medical services furnished by the hospital or facility and process through the BlueCard Program, unless the member receiving such services is enrolled in a benefit plan having an exclusive arrangement with such other licensee of the Association.

4. If and for so long as the hospital or facility is contracted with both Blue Shield and another licensee of the Blue Cross Blue Shield Association in the State of California, and there is no exclusive arrangement with either Blue Shield nor the other license of the Association, the hospital or facility shall increase the number of claims for medical services process through the BlueCard Program (as defined in the Provider Manual) sent to Blue Shield for processing.

5. To facilitate the obligation outlined in 4) above, Blue Shield provides clearinghouses and EDI partners* with tools that improve claims processing accuracy and reduce turnaround time. These are collectively known as the BlueCard Prefix Code Routing Table Edit ("BlueCard Edit" or simply, "Edit"). Unless otherwise noted in the *Provider Contract*; the provider has authorized the implementation and use of these tools for their BlueCard claims in all transmission formats.

Submitting BlueCard Claims *(cont'd.)*

The purpose and functionality of the BlueCard Edit is to direct and route all BlueCard transactions where Blue Shield is eligible to process said claims. This includes all BlueCard transactions that are related to a healthcare member whose healthcare payer is a licensed affiliate of the Blue Cross Blue Shield Association ("BCBSA"). It does not include transactions from prefixes noted in the table that are (i) exclusive to another licensee of the Blue Cross Blue Shield Association in the State of California; or (ii) from those licensed affiliates of BCBSA that designates another licensee of the Blue Cross Blue Shield Association in the State of California exclusively to process transactions for its members.

Other state independent licensee(s) of the Blue Cross Blue Shield Association may select Blue Shield of California or another licensee of the Blue Cross Blue Shield Association in the State of California as the preferred processor of their BlueCard claims in California for particular accounts, groups, procedures, and/or other circumstances. Submitting claims to the wrong processor or payor can cause substantial delays in processing. Blue Shield and its agents will provide best effort to review claims submitted to California processor(s). In the event a claim is submitted to a non-preferred processor, Blue Shield may re-route claims as needed. Re-routing of BlueCard claims may occur in accordance to Blue Shield's agreement(s) with another licensee of the Blue Cross Blue Shield Association. Where other state independent licensee(s) of the Blue Cross Blue Shield Association has selected another independent Blue Cross and Blue Shield licensee in California, as their processor for accounts or groups, Blue Shield will provide best effort to re-route claims to that licensee. This claim review process is integral to our claims processing and claims routing systems and cannot be selectively enabled by Provider. While Blue Shield and its agents will provide best effort; we cannot ensure that 100% of all claims are reviewed prior to Payor delivery. Blue Shield is not responsible for any delays or liability from the provision or non-provision of this service or subsequent re-routing or non-re-routing.

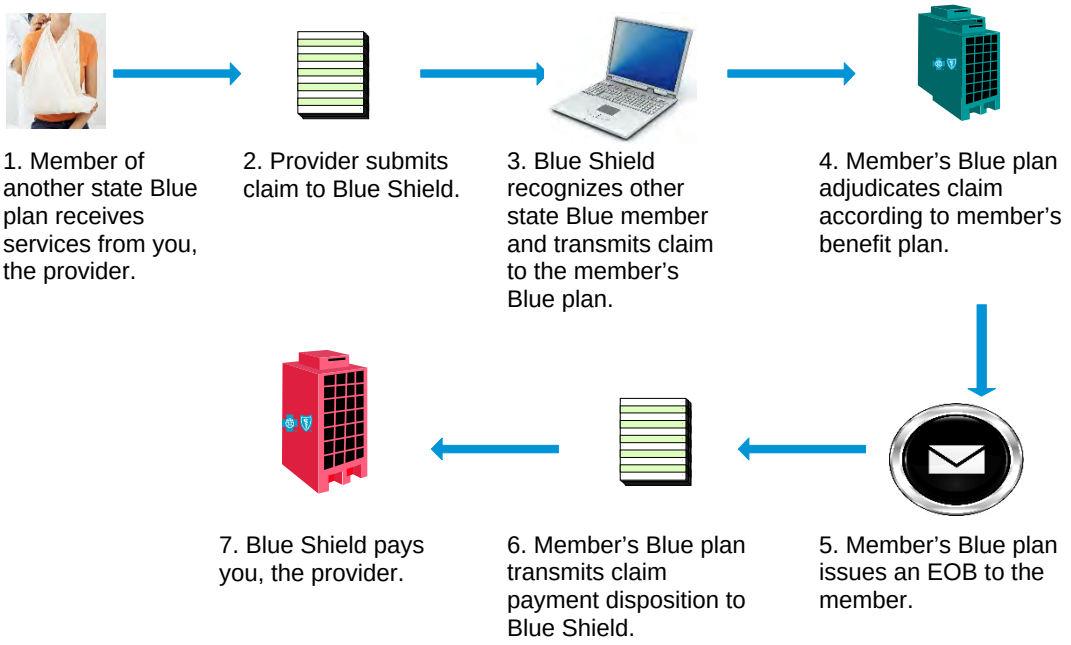
If you have any questions about electronic claim submission, contact our EDI Help Desk at (800) 480-1221.

Submitting BlueCard Claims *(cont'd.)*

In cases where there is more than one payor and Blue Cross and/or Blue Shield is a primary payor, submit Other Party Liability (OPL) information with the Blue Cross and/or Blue Shield claim. Upon receipt, Blue Shield will electronically route the claim to the member's Blue plan. The member's Blue plan then processes the claim and applicable payment. Blue Shield will reimburse you for services.

* If requested, Blue Shield will provide to the provider or their agents or claims clearinghouse (collectively known as the "SUBMITTER") its proprietary BlueCard Prefix Code (also known as the Interplan Teleprocessing System, or "ITS") tables ("Tables") which shall at all times remain the Confidential Information of Blue Shield. Upon provision of the Tables, the Submitter shall develop, implement, and maintain in production the software functionality or program known as the BlueCard Prefix Code Routing Table edit ("BlueCard Edit" or simply, "Edit"). Where such capability currently exists, the provider hereby authorizes and directs their Submitter to make use of said Edit or similar capability. To inquire about the BlueCard Edit, email BlueCardMarketing@blueshieldca.com.

Below is an example of how claims flow through BlueCard



Traditional Medicare-Related Claims

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is primary payor, submit claims to your local Medicare intermediary.
- All Blue claims are set up to automatically cross-over to the member's Blue plan after being adjudicated by the Medicare intermediary.

How do I submit Medicare primary/Blue plan secondary claims?

- For members with Medicare primary coverage and Blue plan secondary coverage, submit the claim first to your Medicare intermediary.
- Be certain that you include the exact name of the secondary plan and the complete subscriber number. The member's Blue plan subscriber number will include the three-character prefix followed by alpha-numeric values.
- When you receive the remittance advice from the Medicare intermediary, verify whether the claim has been automatically forwarded (crossed over) to the secondary payor (Blue plan). If the Medicare remittance advice indicates the claim has been crossed over, it means that Medicare has forwarded the claim, on your behalf, to the appropriate secondary plan for processing. There is no need for you to resubmit the claim to the Blue plan.

When should I expect to receive payment?

The Medicare intermediary will process and cross over the claim within about 14 business days. This means that the Medicare intermediary will be forwarding the claim to the secondary Blue plan on approximately the same date you receive the Medicare remittance advice. Please allow up to 30 additional calendar days before expecting payment or instructions regarding the secondary processing of the claim.

What should I do if I have not received a Medicare remittance advice and/or payment for the claim?

If you submitted the claim to the Medicare intermediary and you have not received a response to your initial claim submission, do not automatically submit another claim to the secondary Blue plan. Instead, please take the following steps:

- Confirm that the Medicare intermediary received the claim and resend it to the Medicare intermediary only if it was not initially received.
- Wait until you receive the Medicare remittance advice for the claim.

Traditional Medicare-Related Claims *(cont'd.)*

- Wait an additional 30 calendar days after you receive the remittance advice to receive payment or instructions from the Blue plan regarding secondary coverage processing.

- If, after 30 calendar days, you have not received payment or instructions from the Blue plan regarding secondary claim processing, we recommend that you submit a secondary claim, including complete Medicare adjudication information, to the local Blue plan, as appropriate.

To avoid having your claim denied by the Blue plan as a duplicate, do not submit a secondary claim to the local Blue plan before taking each of the steps described above.

Whom should I contact if I have questions?

If Blue Shield is the secondary healthcare coverage carrier for the patient, please contact us using the following information:

- Online at www.blueshieldca.com/provider

- Provider Customer Service, by telephone at (800) 541-6652

- Provider Chat feature available online at www.blueshieldca.com/provider

- By postal mail at Blue Shield of California, P.O. Box 272540, Chico, CA 95927-2540

If the patient's secondary plan is a Blue plan in a state other than California, please contact us using the following information:

- BlueCard Provider Customer Service, by telephone at (800) 622-0632

- By postal mail at BlueCard Claims, P.O. Box 272630, Chico, CA 95927-2630

Claims Filing for Air Ambulance Services for BlueCard Patients

Generally, as a healthcare provider you should file claims for your Blue Cross and Blue Shield patients to the local Blue plan. However, there are unique circumstances when claims filing directions will differ based on the type of service rendered.

Claims for air ambulance services must be filed to the Blue plan in whose service area the point of pickup ZIP code is located.

Note: If you contract with more than one Blue plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Blue plan.

Service Rendered	How to File (Required Fields)	Where to File	Example
Air Ambulance Services	**Point of Pickup ZIP Code**: • Populate item 23 on CMS 1500 Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup. • For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional. • Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual. • Form Locators (FL) 39-41. • Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee. • Value: Five digit ZIP code of the location from which the beneficiary is initially placed on board the ambulance. • For electronic claims, populate the origin information (ZIP code of the point of pick-up) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional.	File the claim to the Blue plan in whose service area the point of pickup ZIP code is located*. *BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.	1. The point of pick up ZIP code is in Plan A service area. 2. The claim must be filed to Plan A, based on the point of pickup ZIP code.

If you have questions about the claims filing for Air Ambulance Services for other state Blue plan member, please contact Blue Shield's BlueCard Customer Service Unit at (800) 622-0632.

Medical Records

Under what circumstances may the provider get requests for medical records for other Blue plan members?

- **As part of the pre-authorization process** - If you receive requests for medical records from the member's Blue plan prior to rendering services, as part of the pre-authorization process, you will be instructed to submit the records directly to the member's Blue plan that requested them. This is the only circumstance where you would not submit them to Blue Shield.
- **As part of claim review and adjudication** - These requests will come from Blue Shield in a form of a letter requesting specific medical records and including instructions for submission.

BlueCard Medical Record Process for Claim Review

- An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.
- A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact Blue Shield's dedicated BlueCard Customer Service team at (800) 622-0632 to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.
- If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact Blue Shield's dedicated BlueCard Customer Service team at (800) 622-0632 to determine if the records are needed from your office.
- Upon receipt of the information, the claim will be reviewed to determine the benefits.

Helpful Ways You Can Assist in Timely Processing of Medical Records

- If the records are requested following submission of the claim, forward all requested medical records and a copy of the medical records request letter, to Blue Shield's dedicated BlueCard Customer Service team at: Blue Shield of California, BlueCard Program, P. O. Box 272630, Chico, CA 95927-2630
- Follow the submission instructions given on the request, using the specified address, email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.

Medical Records *(cont'd.)*

- Include the medical records request letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Blue Shield.
- Please submit the information to Blue Shield within 10 days of the request to avoid further delay.
- Only send the information specifically requested. Frequently, complete medical records are not necessary.
- Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

Claims Coding

Code claims as you would for local Blue Shield claims. Please refer to Section 4: Billing and Payment for further claim billing information and requirements.

Claim Payment and Claim Status Inquiries

Blue Shield processes BlueCard claims in accordance with our contract agreement with you. Providers are required to receive claims payments electronically through direct deposit of funds into a provider's designated bank account. Providers are also required to receive Electronic Remittance Advice (ERA) files or view Explanation of Payment (EOP) using the Blue Shield provider portal unless the provider contract specifically states otherwise.

Go to Provider Connection at blueshieldca.com/provider 24 hours a day, seven days a week for current, reliable information on BlueCard claims, payment status, and claim reporting tools.

To obtain status and verify payment information on your BlueCard claims, access the *Claims* section on blueshieldca.com/provider. Use this tool as your primary resource for requesting and receiving details on BlueCard claims.

If you have remaining questions about your BlueCard claims after accessing the *Claims* section on our website, contact Blue Shield's dedicated BlueCard Customer Service Unit at (800) 622-0632.

Calls from Members and Others with Claim Questions

If Blue plan members contact you, advise them to contact their Blue plan and refer them to their ID card for a customer service number.

The member's Blue plan should not contact you directly regarding claims issues, but if the member's Blue plan contacts you and asks you to submit the claim to them, refer them to Blue Shield of California.

Value Based Provider Arrangements

Blue plans have value-based care delivery arrangements in place with their providers. Each Blue plan has created their own arrangement with their provider(s), including reimbursement arrangements. Due to the unique nature of each Blue plan/provider arrangement, there is no common provider education template for value-based care delivery arrangements that can be created and distributed for use by all Blue plans.

Claim Adjustments

Contact Blue Shield's BlueCard Customer Service Unit at (800) 622-0632 if an adjustment is required.

Provider Claim Appeals

Provider claim appeals for all BlueCard claims processed by Blue Shield are handled through Blue Shield. BlueCard claim appeals must be resolved within a 30-day timeframe. We will coordinate the appeal process with the member's Blue plan, if needed. For more information on the BlueCard claim appeal process, contact our BlueCard Customer Service Unit at (800) 622-0632.

You now have the option to submit claim appeal online, in addition to using the existing mail-in process.

How it works

You will need the claim number to get started:

- www.blueshieldca.com/provider/account-tools/login/home.sp, then from the *Claim* page, click the *Claim issues & disputes* at www.blueshieldca.com/en/provider/claims/disputes.

Section 4

BlueCard Resources

Claims Routing Tool

Determining where to submit BlueCard claims is the number one question providers ask about BlueCard claims. To find out which California Blue plan can process your BlueCard claim, access our Claims Routing Tool on Provider Connection at blueshieldca.com/provider within claims section. Simply enter the member's three-character prefix and date of service to instantly learn where to send your BlueCard claim.

BlueCard Video

Blue Shield offers a video online at our Provider Connection website that describes the core processes of the BlueCard Program.

Access our online BlueCard video by logging onto blueshieldca.com/provider, clicking on the *Find BlueCard Program resources* link within the BlueCard section, then select the video on the webpage that appears.

BlueCard Program Tutorials

Access our online BlueCard Program tutorials and quickly learn about our online tools. BlueCard tutorials are available anytime, 24 hours a day, 7 days a week. Select the topics you want to learn about, whenever it's convenient for you.

The tutorials will help you learn how to:

- Verify eligibility and benefits
- Access other Blue plans' medical policies, pre-certification guidelines and request medical authorizations
- Instantly determine where to submit claims with the Claims Routing Tool
- Check claims status, payment details and EOB's

Log into Provider Connection at blueshieldca.com/provider, click on the *BlueCard Program home page* link within the BlueCard Program section on the opening landing page, and select the *Tutorials* link. Then choose from a variety of tutorial modules offered.

BlueCard Program Webinars

We offer complimentary online BlueCard Program training sessions to give providers detailed information about serving other states' Blue plan members and processing BlueCard claims.

To attend one of our monthly webinars, access our *Webinars* link on the BlueCard Program web page on Provider Connection for the date and time. To receive notification about BlueCard webinars, request more information by emailing BlueCardMarketing@blueshieldca.com.

BlueCard Frequently Asked Questions (FAQ) Page

Visit our BlueCard FAQ page to see the most often asked questions by providers about the BlueCard Program and our detailed answers. To access this informative page, log onto blueshieldca.com/provider, click on the *BlueCard Program* home page link, select the *Resources* link, and then choose the *BlueCard Program FAQs* box.

BlueCard Program Educational Resources

A wide variety of BlueCard educational flyers, brochures, and other resources are available on the BlueCard Program web page on Provider Connection.

Section 5

Medicare Advantage

Medicare Advantage Overview

"Medicare Advantage" (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as "traditional Medicare"). It offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans. All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP) which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage by calling (800) 676-BLUE (2583) or submitting an electronic inquiry for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules may vary depending on the Medicare Advantage plan.

Types of Medicare Advantage Plans

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by Medicare Advantage plan.

Types of Medicare Advantage Plans *(cont'd.)*

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine—at the point of service—whether they want to receive certain designated services within the HMO system or seek such services outside the HMO's provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO's provider network.

Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Medicare Advantage PFFS

A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage organization, rather than the Medicare program, pays physicians and providers on a fee-for-services basis for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instance where the provider is a network provider and the plan expressly allows for balance billing.

Types of Medicare Advantage Plans *(cont'd.)*

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with Blue Shield.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue plan.
- Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.
- MA PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield plan, and we advise that you review them before servicing MA PFFS members.
- Submit your MA PFFS claims to Blue Shield.

Medicare Advantage Medical Savings Account (MSA)

A Medicare Advantage MSA plan is made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

Medicare Advantage PPO Network Sharing

What is BCBS Medicare Advantage PPO Network Sharing?

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted MA PPO provider.

What does the BCBS Medicare Advantage (MA) PPO Network Sharing mean to me?

If you are a contracted MA PPO provider with Blue Shield and you see MA PPO members from other BCBS Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Shield contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with Blue Shield of California and you provide services for any BCBS MA members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

Types of Medicare Advantage Plans *(cont'd.)*

Medicare Advantage PPO Network Sharing *(cont'd.)*

How do I recognize an out-of-area member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a MA PPO member when their member ID card has the following logo.

The "*MA*" in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Do I have to provide services to Medicare Advantage PPO members from other Blue Cross Blue Shield Plans?

If you are a contracted Medicare Advantage PPO provider with Blue Shield of California, you must provide the same access to care as you do for Blue Shield MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local Blue Cross Blue Shield Medicare Advantage PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

What will I be paid for providing services to these out-of-area Medicare Advantage PPO network sharing members?

If you are a MA PPO contracted provider with Blue Shield, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, Blue Shield will work with the other Plan to determine benefits and send you the payment.

Types of Medicare Advantage Plans *(cont'd.)*

Medicare Advantage PPO Network Sharing *(cont'd.)*

What will I be paid for providing services to Medicare Advantage out-of-area members not participating in the Medicare Advantage PPO Network Sharing?

When you provide covered services to other BCBS MA out-of-area members', benefits will be based on the Medicare allowed amount. Once you submit the claim, Blue Shield will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.

May I request payment upfront?

Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, co-payment, coinsurance, and non-covered services).

Under certain circumstances when the member has been notified in advance that a service will not be covered, you may request payment from the member before services are rendered or billed to the member. The member should sign an Advance Benefit Notification (ABN) form before services are rendered in these situations.

What is the member cost sharing level and co-payments?

Member cost sharing level and co-payment is based on the member's health plan. You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at (800) 676-BLUE (2583).

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact Blue Shield at (800) 622.0632.

Types of Medicare Advantage Plans *(cont'd.)*

Medicare Advantage PPO Network Sharing *(cont'd.)*

What is BCBS Medicare Advantage PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO BCBS Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted MA PPO provider. MA PPO shared networks are available in 48 states and one territory:

- Alabama
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- Wisconsin
- West Virginia

How to Recognize Medicare Advantage Members

Members of Medicare Advantage plans will not have a standard Medicare card; instead, a Blue Cross and/or Blue Shield logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

Member ID cards for Medicare Advantage products will display one of the benefit product logos shown here:	MEDICARE ADVANTAGE | HMO	Health Maintenance Organization
	MEDICARE ADVANTAGE | MSA	Medical Savings Account
	MEDICARE ADVANTAGE | PFFS	Private Fee-For-Service
	MEDICARE ADVANTAGE | POS	Point of Service
	MA | PPO MEDICARE ADVANTAGE	Network Sharing Preferred Provider Organization

When these logos are displayed on the front of a member's ID card, it indicates the coverage type the member has in his/her Blue plan service area or region. However, when the member receives services outside his/her Blue plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

Blue Shield of California participates in Medicare Advantage PPO Network Sharing arrangements, and contracted provider reimbursement is based on the contracted rate with Blue Shield of California. Non-contracted provider reimbursement is the Medicare allowed amount based on where services are rendered.

Tip: While all MA PPO members have suitcases on their ID cards, some have limited benefits outside of their primary carrier's service area. Providers should refer to the back the member's ID card for language indicating such restrictions apply.

Eligibility Verification

Verify eligibility by contacting Medicare Member Services at **(800)** 676-BLUE (2583) and providing the member's prefix or by submitting an electronic inquiry to Blue Shield and providing the member's prefix. Be sure to ask if Medicare Advantage benefits apply. If you experience difficulty obtaining eligibility information, please record the prefix and report it to Blue Shield.

Medicare Advantage Claims Submission

Submit all Medicare Advantage claims to Blue Shield. Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a Blue plan.

Reimbursement for Medicare Advantage PPO, HMO and POS

No Plan Contract: Services for out-of-area and local Medicare Advantage members

Based upon the Centers for Medicare & Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue plan, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Special payment rules apply to hospitals and certain other entities (such as skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.

> *Note:* Enrollee payment responsibilities can include more than copayments (e.g., deductibles). Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Plan Contract: Services for local Blue Medicare Advantage members

If you are a provider who accepts Medicare assignment and you render services to a local Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue plan, you will be considered a contracted provider and be reimbursed per the contractual agreement.

If you are a provider who accepts Medicare assignment, has a Blue plan contract to provide services for all Medicare Advantage enrollees, and you render services to out-of-area Blue Medicare Advantage members, you will be reimbursed at the contracted rate.

Reimbursement for Medicare Advantage PPO, HMO and POS *(cont'd.)*

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Plan Contract: Services for out-of-area Medicare Advantage Blue members

If you are a provider who accepts Medicare assignment, has a Blue plan contract to provide services for local Medicare Advantage enrollees only, and you render services to out-of-area Blue Medicare Advantage members, you will be reimbursed at the Medicare allowed amount (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.
Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

Reimbursement for Medicare Advantage Private Fee-For-Service (PFFS)

Plan Contract: Services for local Medicare Advantage PFFS member

If you are a provider who accepts Medicare assignment and you render services to a PFFS local Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue plan, you will generally be considered a contracted provider and be reimbursed per the contractual agreement. This amount may be less than your charge amount.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service but may be able to balance bill the member in certain limited instances where the Blue plan with which you contract expressly allows for balancing billing of PFFS members.

Reimbursement for Medicare Advantage Private Fee-For-Service (PFFS) *(cont'd.)*

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

Services for out-of-area Blue Medicare Advantage PFFS members

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, but are not obligated to provide services to such member under a contract with a Blue plan, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member and you are obligated to provide services to such member under a contract with a Blue plan, you will generally be reimbursed at your contracted rate.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

Medicare Advantage Coordination of Care Program

The national MA Coordination of Care program aims to increase the quality of members' care by enabling Blue MA PPO group members to receive appropriate care, wherever they access care.

To better support all Blue MA PPO group members residing in California, Blue Shield is working with providers to improve these members' care through:

- Supporting providers with additional information about open gaps in care
- Requesting medical records to give Plans a complete understanding of member health status

MA PPO group members participating into this program can be identified as having a member address in California and based on the following logo included on their Blue Cross and/or Blue Shield ID Cards:

Reimbursement for Medicare Advantage Private Fee-For-Service (PFFS) *(cont'd.)*

What does this new program to support Blue Medicare Advantage members mean to me?

This program will result in some changes, including a number that will be beneficial to you, your practice, and your patients. The program serves all MA PPO group members that reside in Blue Shield's service area, and some of the benefits that you may see include:

- You will receive consolidated information on gaps in care and risk adjustment gaps, as well as medical record requests for all Blue MA PPO members enrolled with Blue Shield and other Blue Plans and residing in California through local communication practices.
- The MA PPO group members that you see may come into your practice setting more frequently for care due to Blue Shield's requesting care gap closures, allowing for greater continuity in care.

Reminder: As outlined in your contract with Blue Shield, you are required to respond to requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. This includes requests from Blue Shield related to this program.

Section 6

Health Insurance Marketplaces (Exchanges)

Health Insurance Marketplaces Overview

The Patient Protection and Affordable Care Act of 2010 provides for the establishment of Health Insurance Marketplaces (i.e., Exchanges), in each state, where individuals and small businesses can purchase qualified insurance coverage through internet websites. The intent of the Marketplace is to:

- Create a more organized and competitive health insurance marketplace by offering consumers a choice of health insurance plans,
- Establish common rules regarding insurance offerings and pricing,
- Provide information to help consumers better understand the options available to them and,
- Allow individual and small businesses to have the purchasing power comparable to that of large businesses.

The Marketplaces makes it easier for consumers to compare health insurance plans by providing transparent information about health insurance plan provisions such as product information, premium costs, and covered benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.

Each state is given the option to set-up its own "state-based" Marketplace approved by HHS for marketing products to individual consumers and small businesses. If states do not set up a state-based marketplace, the Department of Health and Human Services (HHS) establishes a federally facilitated Marketplace, federally-supported Marketplace, or a state-partnership Marketplace in the state. Blue plans that offer products on the Marketplaces collaborate with the state and federal governments for eligibility, enrollment, reconciliation, and other operations to ensure that consumers can seamlessly enroll in individual and small business health insurance products. Blue Shield of California has on-Exchange state-subsidized plans available for purchase through Covered California. Information on Covered California plans offered by Blue Shield can be accessed through Provider Connection at blueshieldca.com/provider. Click on *Guidelines & resources* at the top of the landing page, then *Healthcare reform* in the top right.

Health Insurance Marketplaces Overview *(cont'd.)*

Exchange-Purchased Plans - Individual Grace Period

The Patient Protection and Affordable Care Act (PPACA) mandates a three month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally mandated individual grace period, providers may receive a notification from Blue Shield of California indicating that the member is in the grace period.

Exchange Individual Grace Period – Post Service Notification Letter to Provider

Communication to providers will include the following information:

1. Notice-unique identification number (claim includes member information):

   Claim #: _____

2. Name of the QHP and affiliated issuer (Blue plan name):

3. Explanation of the three month grace period:

   Under the Patient Protection and Affordable Care Act (PPACA), there is a three month grace period under Exchange-purchased individual insurance policies, when a premium due is not received for members eligible for premium subsidies. During this grace period, carriers may not disenroll members and, during the second and third months of the grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid.

4. Purpose of the notice, applicable dates of whether the enrollee is in the second or third month of the grace period & individuals affected under the policy and possibly under care of the provider:

   Please be advised that a premium due has not been received for this subsidy eligible member and that the member and any eligible dependents are and at the time that your care was provided, were in the second or third month of the Exchange individual health insurance grace period. The above-referenced claim thus was pended due to non-payment of premium and will be denied if the premium is not paid by the end of the grace period.

Health Insurance Marketplaces Overview *(cont'd.)*

5. Consequences:

   If the premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.

6. QHP customer service telephone number:

   Please feel free to contact Blue Shield of California, Monday through Friday, at our Provider Customer Service Unit at (800) 541-6652 if you have any questions regarding this claim.

Health Insurance Marketplaces Claims

The products offered on the Marketplaces will follow local business practices for processing and servicing claims. Providers should continue to follow current practices with Blue Shield of California for claims processing and handling such as outlined below.

1. Eligibility and Benefits
2. Care Management
   a. Pre-Service Review
   b. Medical Policy
3. Claim Pricing and Processing
   a. Contracting
   b. Claim Filing
   c. Pricing
   d. Claim Processing
   e. Medical Records
   f. Payment
   g. Customer Service

Health Insurance Marketplaces Overview *(cont'd.)*

Health Insurance Marketplaces Claims *(cont'd.)*

How can I get more information about Health Insurance Marketplaces (Exchanges)?

If you would like more information about Health Insurance Marketplaces (Exchanges), log onto Provider Connection at blueshieldca.com/provider. Once you are logged onto our provider portal, follow these steps for more information:

1. Click on *Guidelines & resources* at the top of the landing page.
2. Click on *Healthcare reform* in the top right.
3. On the next page, click on the link *Products and Networks Available through Covered California.*

Here, you will find a wide variety of provider and member resources to enhance your understanding of Health Insurance Marketplaces.

Who do I contact if I have a question about Health Insurance Marketplaces (Exchanges)?

If you have any questions regarding the Health Insurance Marketplaces, please contact Blue Shield's Provider Customer Service Unit at (800) 541-6652.

Section 7

Glossary of BlueCard Program Terms

Administrative Services Only (ASO)	ASO accounts are self-funded, where the local plan administers claims on behalf of the account but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits, or timely filing limitations. Blue Shield of California receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.
Affordable Care Act	The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.
bcbs.com	Blue Cross and Blue Shield Association's website, which contains useful information for providers.
BlueCard Access	Providers or members can use this toll-free number (800) 810-BLUE (2583) to locate healthcare providers in another Blue plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.
BlueCard Doctor and Hospital Finder	A website providers and members can use to locate providers in another Blue Cross and Blue Shield plan's service area. This is useful when you need to refer the patient to a physician or healthcare facility in another location. You can access provider information for all 50 states as well as the BlueCard Worldwide network through blueshieldca.com. Click on *Find a Doctor* and then click on the *Providers outside of CA* link on the bottom of the page.

BlueCard *Eligibility®*	Providers can use this toll-free eligibility line at (800) 676-BLUE (2583) to verify membership and coverage information and obtain pre-certification on patients from other Blue plans. Providers can also access eligibility and benefits information for other Blue plan members by accessing blueshieldca.com/provider.
BlueCard PPO	A national program that offers members traveling or living outside of their Blue Shield plan's service area the PPO level of benefits when they obtain services from a physician or hospital designated as a PPO provider.
BlueCard PPO Basic	A national program that offers members traveling or living outside of their Blue Shield Plan's service area the PPO basic level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO Basic provider. When you see the "PPOB" in a suitcase logo on the front of the member's Blue Plan ID card, it means the member has selected a PPO plan product from a Blue Cross Blue Shield plan. Since Blue Shield of California does not have a BlueCard PPO Basic network, providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California
BlueCard PPO Member	A Blue plan patient who carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO. 
BlueCard PPO Network	The network comprising those physicians, hospitals and other healthcare providers PPO members may elect to use to obtain the highest level of PPO benefits.
BlueCard PPO Provider	A doctor, hospital or other healthcare entity enrolled in a network of designated PPO providers.

BlueCard Traditional	A national program that offers members traveling or living outside of their Blue plan's service area the traditional, or indemnity, level of benefits when they obtain services from a physician or hospital outside of their Blue plan's service area. These members will carry an ID card featuring an "empty" suitcase logo.
Blue High Performance Network (BlueHPN)	A national network of providers offered in key geographies that provides national accounts enhanced quality and cost savings.
Blue Shield Global Core®	A program that allows Blue plan members traveling or living outside of the United States to receive healthcare services from participating international Blue plan healthcare providers. The program also allows members of international Blue plans to access U.S. Blue plan provider networks. The Global Network of participating providers can be accessed through blueshieldca.com. Click on *Find a Doctor* and then click on the *Providers outside of CA* link on the bottom of the page.
Consumer Directed Health Care/Health Plans (CDHC/CDHP)	Consumer Directed Health Care (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. CDHC plans provide the member with additional information to make an informed and appropriate decision through the use of member support tools, provider and network information, and financial incentives.
Coinsurance	A provision in a member's coverage that limits the amount of coverage by the plan to a certain percentage. The member pays any additional costs out-of-pocket.
Coordination of Benefits (COB)	Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.
Copayment	A specified charge that a member incurs for a specified service at the time the service is rendered.

Deductible	A flat amount the member incurs before the insurer will make any benefit payments.
Electronic Provider Access	Electronic Provider Access (EPA) is an online tool giving providers the ability to access out-of-area members' Blue plan provider websites to request medical authorization and pre-service review. To access the EPA tool, log onto Provider Connection at blueshieldca.com/provider and click on *Pre-service review for out-of-area members* in the *Authorizations* section on the opening landing page. Choose the *Electronic Provider Access* option and you will be connected directly to the Blue plan within a secured routing mechanism to begin your request.
Essential Community Providers	Healthcare providers that serve predominantly low-income, high-risk, special needs and medically-underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.
Exclusive Provider Organization (EPO)	An Exclusive Provider Organization is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.
FEP	The Federal Employee Program.
Hold Harmless	An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed with a Blue plan as full payment for these services.

Marketplace Exchange	For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards. The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a federally-facilitated Marketplace in any state that does not do so.
Medicaid	A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women, Medicaid is governed by overall federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).
Medicare Advantage	Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare." MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.
Medicare Crossover	The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

Medicare Supplemental (Medigap)	Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the "gaps" in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn't cover. Medigap policies are regulated under federal and state laws and are "standardized." There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell. Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member's Home Plan via Medicare Crossover process. Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments, or other cost-sharing.
National Account	An employer group with employees and/or retirees located in more than one Blue plan service area.
Other Party Liability (OPL)	A cost containment program that ensure Blue plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers' Compensation, subrogation, and no-fault auto insurance.
Plan	Refers to any Blue Cross and/or Blue Shield plan member's health care service coverage, e.g., HMO, PPO, EPO, and POS.
Point of Service (POS)	Point of Service is a health benefit program in which the highest level of benefits is received when the member obtains services from his/her primary care provider/group and/or complies with referral authorization requirements for care. Benefits are still provided when the member obtains care from any eligible provider without referral authorization, according to the terms of the contract.

PPOB	A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.
Preferred Provider Organization (PPO)	Preferred Provider Organization is a health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.
Prefix	The three characters preceding the subscriber identification number on the Blue plan ID cards. The prefix identifies the Blue plan or national account to which the member belongs and is required for routing claims.
Provider Connection	Blue Shield's provider website at blueshieldca.com/provider contains useful information for our providers including basic BlueCard patient administration and claims processing steps, eligibility and benefits information on other Blue plan members, and instructions on where to send BlueCard claims by accessing our Claims Routing Tool.
Qualified Health Plan (QHP)	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.
Small Business Health Options Program (SHOP)	Allows employers to choose the level of coverage and offer choices among health insurance plans. State-run Marketplaces were scheduled to become available by January 2014, with the federal government stepping in to run Marketplaces for states that were not ready. In 2016, all businesses with 100 or fewer employees must be able to purchase insurance through these Exchanges. The Marketplaces have the option of including employees with more than 100 employees beginning in 2017.

State Children's Health Insurance Program (SCHIP)	SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.
Traditional Coverage	Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance, or copayments.

Table of Contents

Appendix for Section 6

This page intentionally left blank.

Blue Shield Combined Eligibility/Capitation Report

COMMERCIAL

FIELD NAME	NOTES	FIELD LENGTH
CapitatedEntity		12
CapitatedEntityEffDate		10
CapitatedEntityCancelDate		10
ActivityType	A, T, R, C, blank	9
MemberLastName		35
MemberFirstName		15
MemberMiddleInitial		1
MemberCertNumberCurrent	Sub ID + SFX	14
MemberCertNumberPrevious		14
MemberRelationship	E, S, D	1
MemberAddressLine1		40
MemberAddressLine2		20
MemberAddressLine3		20
MemberCity		20
MemberState		2
MemberZipCode		10
MemberPhoneNumber		20
MemberGender		1
MemberAge		3
MemberDateOfBirth		10
MemberLanguagePref		4
SubscriberSsn		9
PCPID		12
NPIforPCP		10
PCPName		55
PCPEffDate		10
PCPCxlDate		10
GroupID		8
GroupName		50
GroupType		10
GroupEffDate		10
GroupRenewalDate		10
ProductID		8
ProductIdDescription		115
ProductIdEffDate		10
PlanID		8
PlanName		70
NetworkId		12
AlphaPrefix		4

Blue Shield Combined Eligibility/Capitation Report

FIELD NAME	NOTES	FIELD LENGTH
ClassId		4
LineOfBusinessId		4
LineOfBusinessDescription		50
CostAccountingCategory		3
OfficeVisitCopayAmount		3
IndivDeductibleAmount		7
FamilyDeductibleAmount		7
CobFlag		1
CobOrder		1
CobEffDate		10
CobTermDate		10
CobOtherCovId		9
CobOtherCovDescription		50
EarnedDate		10
CapitationAmount		11
AdminFeeAmount		11
OtherPayAmount		11
MemberMonths		11
ReasonCode		4
GroupCapConvertDate		10
SubConvertDate		10
SrcSysId	FACETS	10
Grace Period Start Date		10
Grace Period End Date		10
Grace Period Suspended Date		10
Anticipated End Date if no payment		10

Blue Shield Combined Eligibility/Capitation Report

MEDICARE

Field Number	FieldName	FiedDesc	Format (if applicable)	Max Length	Data Type	Prior Field Name (If applicable)	Notes
1	CapitatedEntity	BSC Facets IPA number		12	Text	IPA_Code	Medicare Site IDs are now identical to the equivalent 12 character commercial IDs
2	CapitatedEntityEffDate	Member effective date with IPA	YYYY-MM-DD	10	Date	IPA_Eff_Date	
3	CapitatedEntityCancelDate	Member cancel date with IPA	YYYY-MM-DD	10	Date	IPA_Cancel_Date	
4	ActivityType	A, R, C, T, Blank		2	Text	Activity	Medical Group **R** = Member added then terminated from the IPA Medical Group for the purpose of paying retro capitation **C** = Change in assigned PCP, no change to assigned IPA **T** = Member terminated from the IPA Medical Group **Blank** = Member continues eligibility with no changes
5	MemberLastName	Member last name		35	Text	Last_Name	
6	MemberFirstName	Member first name		15	Text	First_Name	
7	MemberMiddleInitial	Member middle initial		1	Text		
8	MemberCertNumberCurrent	BSC member ID	NNNNNNNNN-NNN	13	Text	Member_No	Same format as commercial ID
9	MemberCertNumberPrevious	Previous BSC member ID		14	Text	Prior_Mbr#	Legacy system ID (if available)
10	MemberAddressLine1	Member address		40	Text	Street_Address	
11	MemberAddressLine2	Member address		40	Text		
12	MemberAddressLine3	Member address		40	Text		
13	MemberCity	Member city		20	Text	City	
14	MemberState	Member state		2	Text	State	
15	MemberZIPCode	Member ZIP		5	Text	ZipCode	
16	MemberPhoneNumber	Member phone number		20	Text	Phone_No	
17	MemberGender	Member gender		1	Text	Sex	
18	MemberAge	Member age	0	3	Number	Age	
19	MemberDateOfBirth	Member date of birth	YYYY-MM-DD	10	Date	DOB	
20	MemberLanguagePref	Member language (ie EN, SP)		4	Text	e	
21	HICN	Medicare (CMS) Health Insurance Number (HICN)		12	Text		CMS HICN number
22	PcpID			12	Text	PCP_No	Same format as commercial PCP ID, for capitated hospital, this field contains the IPA number, not PCP
23	NPIforPCP			10	Text	NPI	
24	PcpName			55	Text	PCP_Name	Name, for capitated hospital, this field contains the IPA name, not PCP
25	PcpEffDt		YYYY-MM-DD	10	Date	PCP_Eff_Date	

Blue Shield Combined Eligibility/Capitation Report

Field Number	FieldName	FiedDesc	Format (if applicable)	Max Length	Data Type	Prior Field Name (If applicable)	Notes
25	PcpEffDt		YYYY-MM-DD	10	Date	PCP_Eff_Date	
26	PcpCxlDt		YYYY-MM-DD	10	Date	PCP_Cancel_Date	
27	GroupID			8	Text	Group_ID	GroupID for IMAPD, GroupID for GMAPD will be the same as the commercial Facets ID (if any).
28	GroupName			50	Text		Employer group name
29	ProductID			8	Text	Current_Coverage_Code	ProductID varies by county for IMAPD and by employer group for Group Medicare.
30	ProductIDDescription			115	Text	Current_Coverage_Desc	Text field describes product IMAPD or GMAPD
31	ProductIDEffDate		YYYY-MM-DD	10	Date	ff	
32	PlanID			8	Text		
33	PlanName			70	Text		
34	NetworkID	MGMAPD000001 - Group Medicare Advantage MIMAPD000001 - Blue Shield 65 Plus MIMAPD000002 - Blue Shield 65 Plus Choice		12	Text		12 character network ID identifies Group, Individual, or Choice Medicare
35	OfficeVisitCopayAmount		0	3	Number	Office_Copay_Amt	
36	MedicaidStatus	or N		1	Text	Medicaid_Status	
37	CobFlag	Indicates other coverage Y or N		1	Text		
38	CobOtherCoverageDescription			50	Text	Other_Coverage_ID	CIGNA, BLUE CROSS etc. if available)
39	EarnedDate		YYYY-MM-DD	10	Date	SVC_Month	paid
40	CapitationAmount		0.00	18	Currency	Capitation_Amount	Core capitation payment
41	AdminFeeAmount		0.00	18	Currency	Admin_Amount	Admin fee (if any)
42	OtherPayAmount		0.00	18	Currency	Other_Cap_Amount	Medicare Advantage premium (if any).
43	ReasonCode	One adjustment code i.e. 42 Two adjustment codes i.e. 10, 08		10	Text		All HCFA 2 digit adjustment reason codes that occur in a given payment month
44	RiskScore	CMS risk score i.e. 1.089	NN.DDDD	7	Number	Risk_Scores	
45	CountyCode	CMS county code i.e. 200	NNN	3	Text	County_Code	
46	StateCode	CMS state code i.e. 05	NN	2	Text	State_Code	
47	MedicaidAddOn	Y or N		1	Text	Medicaid_Add-On	used in calculating the risk score, i.e., at least a one month period of Medicaid eligibility during the data collection period was established in CMS systems at the time that risk scores were calculated.
48	HealthStatus	i.e. E would indicate ESRD, H for Hospice		10	Text	Health_Status	
49	ExceptionCode	T or blank		1	Text	Exception_Code	capitation if HCFA risk, health status or Demo code unavailable or in dispute)
50	MemberMonthCount	1, or -1		2	Number	Member_Month_Counter	Indicates 1, -1 for events equating to a full member month being added or backed out.

Blue Shield Eligibility Adds and Termination Report

FIELD NAME	NOTES	FIELD LENGTH
CapitatedEntity		12
CapitatedEntityEffDate		10
CapitatedEntityCancelDate		10
ActivityType	A, T, R, C, blank	9
MemberLastName		35
MemberFirstName		15
MemberMiddleInitial		1
MemberCertNumberCurrent	Sub ID + SFX	14
MemberCertNumberPrevious		14
MemberRelationship	E, S, D	1
MemberAddressLine1		40
MemberAddressLine2		20
MemberAddressLine3		20
MemberCity		20
MemberState		2
MemberZipCode		10
MemberPhoneNumber		20
MemberGender		1
MemberAge		3
MemberDateOfBirth		10
MemberLanguagePref		4
SubscriberSsn		9
PCPID		12
NPIforPCP		10
PCPName		55
PCPEffDate		10
PCPCxlDate		10
GroupID		8
GroupName		50
GroupType		10
GroupEffDate		10
GroupRenewalDate		10
ProductID		8
ProductIdDescription		70
ProductIdEffDate		10
PlanID		8
PlanName		70
NetworkId		12

FIELD NAME	NOTES	FIELD LENGTH
RiderCode	may not be available	
ClassId		4
LineOfBusinessId		4
LineOfBusinessDescription		50
CostAccountingCategory		3
OfficeVisitCopayAmount		3
IndivDeductibleAmount		7
FamilyDeductibleAmount		7
CobFlag		1
CobOrder	P/S different than Legacy	1
CobEffDate		10
CobTermDate		10
CobOtherCovId		9
CobOtherCovDescription		50
GroupCapConvertDate		10
SubConvertDate		10
SrcSysId	FACETS	10

Claims, Compliance Program, IT System Security, and Oversight Monitoring

A Supplement to the Hospital and Facility Guidelines

February 2025

Claims, Compliance Program, IT System Security, and Oversight Monitoring

This supplement has been written as a guide for a "Delegated Entity." A Delegated Entity refers to delegated hospitals, specialty plans/vendors medical service organizations, third party administrators (TPAs) or others who process claims delegated by Blue Shield of California (Blue Shield). Blue Shield hopes the information and procedures in this supplement will assist in meeting delegated requirements for Claims, Compliance Program, IT System Security, and other Regulatory Oversight Monitoring. For any questions or further assistance, please contact your assigned Delegated Oversight Auditor(s). This supplement includes the following sections:

- Claims Introduction
- Key Terms and Definitions
- Measuring Timeliness and Accuracy
- Best Practices and Claims Adjudication
- Compliance Program Effectiveness Oversight Audit (Includes Oversight of Controls)
- IT System Security
- Oversight Monitoring
- Claims Delegate Reporting Instructions

Claims, Compliance Program, IT System Security, and Oversight Monitoring

Claims Introduction

This supplement to the Blue Shield *Hospital and Facility Guidelines* is for the delegated hospitals that 1) processes its own claims, 2) contracts with a management company or Third-Party Administrator (TPA) to process claims on its behalf, or 3) sub-capitates (sub-delegates) some or all of its claims processing responsibilities. If the Delegated Entity is currently not processing their claims, the Delegated Entity must share this supplement with their TPA or management company or otherwise ensure that they have the latest version of this specific update. If the Delegated Entity sub-capitates claims processing, or ever contemplates doing so, please carefully read the "Monitoring of a Subcontractor (this includes MSO) for a delegated function-offshore/onshore" section of this appendix below. It explains the additional responsibilities for a Delegated Entity who sub-capitates the claims processing function.

By means of this supplement, Blue Shield seeks to describe and follow sound operating principles. This supplement will guide you in applying regulatory requirements and industry best practices in claims operations. Please do not hesitate to contact your assigned Blue Shield Delegated Claims Oversight Auditor directly for further information or assistance.

Based on the available data, the information in this supplement conforms to all Centers for Medicare & Medicaid Services (CMS) and Department of Managed Health Care (DMHC) requirements. Should information in this supplement fail to reflect any existing or newly enacted statutory requirements, these new or additional requirements will supersede the information contained herein. Blue Shield will notify the Delegated Entity of any changes in requirements through supplemental revisions or by other written communications. Throughout this document, wherever possible, Blue Shield distinguishes between Medicare Advantage (HMO) requirements and DMHC ("commercial") requirements or citations.

This supplement only describes claims, compliance program effectiveness including internal controls, IT system security, and oversight monitoring. Information on other claims-related topics (i.e., claims operations coordination with Blue Shield; submission of encounter claims or data; claims appeals or grievances; Medicare Secondary Payment (MSP); and coordination of benefits (COB)) are covered in other parts of the *Hospital and Facility Guidelines*.

Key Terms and Definitions

Claims Operations

Blue Shield monitors compliance and deficiencies across all aspects of Delegated Entity's claims operations: receipt and related handling, processing/adjudication, and payment. The claim operation begins when the claim is first received from the US Postal Service, electronically or by any other means and ends when the check or disbursement, explanation of benefits (EOB) or notice of denial is electronically transmitted or deposited in the US mail. These operations are defined to include computer systems and their reports, as well as utilization review, and any other ancillary operations in the workflow needed to fully process a claim and deliver the payment and/or denial.

Clean Claim – Medicare Advantage

A clean claim is defined as "one which can be paid and/or denied as soon as it is received, because it is complete in all aspects, including complete coding, itemization, dates of service, billed amounts, and identification of the billing provider including tax identification number (TIN)" and the national provider identifier (NPI).

A "clean" claim is one that does not require the payer to develop external to their Medicare operation on a prepayment basis. Clean claims must be filed in the timely filing period. A clean claim has all basic information necessary to adjudicate the claim, and all required supporting documentation.

Emergency services or out-of-area urgently needed services do not need authorization to be considered "clean," providing that the presenting ICD-10-CM diagnoses codes or accompanying medical records substantiate that they qualify as emergent, urgent under the reasonable person standard.

Complete Claim

A complete claim is one that includes all necessary information to determine payor liability. Information necessary to determine payor liability for the claim includes, but is not limited to, reports or investigations concerning fraud and misrepresentation, necessary consents, releases and assignments, or other information necessary for the delegated claims operation to determine the medical necessity for the health care services provided.

Emergency services or out-of-area urgently needed services do not need authorization to be considered "complete," providing that the diagnoses codes or accompanying medical records substantiate that they qualify as emergent, urgent under the reasonable person standard.

Key Terms and Definitions *(cont'd.)*

Compliance

Compliance means conforming to a rule, such as a specification, policy, standard or law. Regulatory compliance describes the goal that organizations aspire to achieve in their efforts to ensure that they comply with relevant laws, policies, and regulations.

Contested Claims - Commercial

A contested claim is defined as a claim or portion thereof that is reasonably contested where the delegated claims operation has not received the completed claim and all information necessary to determine payor liability or has not been granted reasonable access to information concerning provider services. When appropriate, claims may need to be contested for additional information, e.g., medical records and chart notes. Contested claims include provider denials and claims pended or closed before a coverage determination can be made. Commercial contested claims must be adjudicated within 45 working days of the received date to be considered compliant.

Delegated Entity will be audited against and must maintain compliance with Claims Settlement Practices in accordance with Title 28 Section 1300.71 (a)(8)(H) and (I) contesting claims for Medical Records.

(H) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to a plan or a plan's capitated provider by all providers over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with the section (a)(2). The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices.

(I) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the plan's or the plan's capitated providers for emergency room service and care over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with section (a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices.

Upon receipt of additional information, a new 45-working day cycle begins.

Key Terms and Definitions *(cont'd.)*

Date of Payment

The date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record.

Date of Receipt

Commercial

The working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's contracted Delegated Entity for that claim. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

Medicare Advantage

The working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, clearing house, or to the plan's contracted Delegated Entity for that claim. For Medicare Advantage, the earliest date, either from Blue Shield or any of the Blue Shield's Delegated Entities, determines the received date of the claims unless documentation can be provided to validate that the earliest stamp(s) does not belong to the Blue Shield network.

Delegated Entity

Any party who enters into a legal agreement by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.

HMO

Health Maintenance Organization. A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. Generally, an HMO will not cover out-of-network care except in an emergency or when authorized.

Incomplete Claims

A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which does not provide: "reasonably relevant information" and "information necessary to determine payor liability."

Key Terms and Definitions *(cont'd.)*

Medicare Advantage

The product line offered to enrolled members who have Medicare Part A and Part B and reside within the plan's service area.

Member Denial

An adverse benefit determination in which a claim, or any line item(s) on a claim, will not be paid and the member is responsible for payment of the service. Non-eligibility, not authorized non-contracted, and/or excluded services are examples of potential member liability denials

Closing a claim without issuing a payment is not a member denial unless the member is responsible to pay for the services rendered. A second denial notice may not be mailed to the member for the service provided.

Monitoring Oversight

Federal and state regulations specifically requires oversight of compliance of Delegated Entities. Oversight of the Delegated Entity for compliance ensures that Blue Shield is compliant with federal and state requirements. Blue Shield in partnership with the Delegated Entity's performs the required oversight of designated operational areas to detect deficiencies early and implement corrective actions.

Principal Officer

Each Delegated Entity that has claims delegated must designate a Principal Officer for claims and provider disputes. The Principal Officer is responsible for attesting to compliant operations and for reporting the timeliness of those operations. The Principal Officer is the president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions (California Code of Regulations (CCR) Title 28 1300.45 (o)). Blue Shield follows the DMHC requirement of a Principal Officer and does not accept a level of Director or below.

Specific to claims, the Principal Officer must sign the quarterly timeliness reports for both claims and provider disputes and Disclosure of Emerging Claims Payment Deficiencies. To designate an individual as Principal Officer or report a change of Principal Officer, request a form from Blue Shield assigned claims auditor or retrieve the form available at the HICE website and submit an original copy with original signatures to Blue Shield. The Principal Officer form should be submitted by email to ClaimsDelegateReport@blueshieldca.com.

Key Terms and Definitions *(cont'd.)*

Provider Dispute Resolution (PDR)

A written provider dispute that includes all information required under state regulations:

(1) Clear identification of the disputed item(s).

(2) The date of service(s)

(3) Clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, denial, or other action is incorrect.

Provider Dispute Resolution (PDR) Process - Commercial

A provider's written notice challenging, appealing, or requesting reconsideration of a claim (or a bundled group of similar multiple claims that are individually numbered) that has been denied, adjusted, contested, or seeking resolution of a billing determination or other contract disputes or disputing a request for reimbursement of an overpayment of a claim.

Provider Dispute Resolution (PDR) Process – Medicare Advantage

A formal process for receiving, resolving, and reporting provider disputes for Medicare Advantage claims Including decisions where a non-contracted provider contends that the amount paid by the payer for a covered service is less than the amount that would have been paid under Original Medicare.

Unaffiliated/Non-Contracted Provider

Commercial

A provider with whom the plan and/or its contracted Delegated Entity does not have a signed contractual agreement in place on the date of service (often referred to as a non-contracted or out of network provider). A contractual agreement can be an actual written contract, a one-time letter of agreement (LOA), a memorandum of understanding (MOU), or a provider rendering services while on-call or covering for a contracted provider. Delegated Entities may not utilize Blue Shield reciprocity and/or PPO rates without the written consent of the health plan. Commercial non-contracted provider claims must be adjudicated within 45 working days of the received date to be considered compliant.

Medicare Advantage

A provider with whom the plan and/or its Delegated Entities does not have a signed contractual agreement in place on the date of service (often referred to as a non-contracted or out of network provider). A non-contracted/unaffiliated provider claim must be adjudicated within 30 calendar days from the earliest date received to be considered compliant.

Key Terms and Definitions *(cont'd.)*

Unclean Claims – Medicare Advantage

An "unclean claim" is an incomplete claim, a claim that is missing information, or a claim that has been developed in order to get more information from the provider.

Measuring Timeliness and Accuracy

Timeliness for claims and disputes is measured from the date the claim or provider dispute is received to the date the check or disbursement, explanation of benefits, denial notice, or dispute resolution correspondence is mailed.

Acknowledgement of Receipt

Commercial

The Delegated Entity must acknowledge receiving electronic claims within two (2) working days of date of receipt of the claim and paper claims within 15 working days of date of receipt of the claim.

Acknowledgement timeframes are based on the date of receipt. The acknowledgment date for electronic submission claims should be either the date the claim became available to the Delegated Entity from their clearing house or the date the claim arrived directly via direct electronic delivery.

Acknowledgement must be in the same manner as the claim was submitted or provided by electronic means, by phone, website, or another mutually agreed upon accessible method of notification. (CCR Title 28 Section 1300.71(c)).

Blue Shield will validate Delegated Entity/MSO website to assure that directions are provided for a non-contracted provider regarding how they can confirm receipt of claim.

Commercial Provider Dispute Resolution (PDR)

The Delegated Entity must acknowledge receiving electronic provider disputes within two (2) working days of receipt and paper provider disputes within 15 working days of receipt.

Measuring Timeliness and Accuracy *(cont'd.)*

Check Cashing Timeliness

Blue Shield accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented via a formal Policy and Procedure. As evidence that the check has been mailed, the Delegated Entity can provide a check mail log that has been signed by a Principal Officer or CFO who is attesting to checks being mailed on the dates reported. Blue Shield will confirm the date the check or electronic transfer was cleared the Delegated Entity's bank account during the audit process. Blue Shield requires that a minimum of 70% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed. If the check clearing timeliness is below 70% Blue Shield requires the Delegated Entity to submit a check cashing attestation to be completed by each provider. The attestation can be requested from your assigned claims delegation oversight auditor.

Fee Schedule Accuracy

Commercial

Contracted providers must be paid accurately at contracted rates. During a claims delegation audit this is demonstrated by the Delegated Entity providing the header page and the signature page of the provider contract with the fee schedule and evidence of the system configuration.

Non-contracted providers may be paid at a reasonable and customary (R&C) fee schedule which requires the Delegated Entity as mandated by Title 28 CCR 1300.71(a)(3):

(B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and

(C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's *Evidence of Coverage.*

Measuring Timeliness and Accuracy *(cont'd.)*

Fee Schedule Accuracy *(cont'd.)*

Medicare Advantage

Title 42, Part 422, Section 214 mandates that "Any provider that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in a Medicare Advantage private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare."

Blue Shield will accept the following in determining accuracy on non-contracted 30-day claims based on the location on where the services were rendered:

(1) "Participating" providers are paid at a published Medicare fee schedule less any standard copayment amount,

(2) "Non-participating" providers who accept assignment are paid 95% of a published Medicare fee schedule less any standard copayment amount,

(3) "Non-participating" providers who do not accept assignment are paid at the "Limiting Charge," This charge is the amount that non-participating providers are "limited" to charge for that service. The amount is 115% of the non-par fee allowance service, and,

(4) Merit Based Incentive Payment System (MIPS) payment adjustments are applied on a claim-by-claim basis, to payments made for covered professional services furnished by a MIPS eligible clinician. CMS assigns a maximum + & - MIPS adjustments payment percentage to every year. The MIPS Payment Adjustment Data File for Delegated Entities is located on the Delegation Claims Oversight Share Point site. Reach out to your assigned auditor if access is needed.

Interest Accuracy

Commercial

Interest is applicable for contracted and non-contracted provider claims paid beyond the statutory deadline. Interest must be calculated beginning the first day after deadline through the day the payment/check is mailed.

Interest is due on adjustments paid in favor of the provider (in whole or in part) when the Delegated Entity was at fault with the original claim process. Interest would be calculated from the original received date of the claim through the date of the mailing of the adjustment payment.

The interest rate is fixed at a 15% annual rate. The amount of interest is calculated by multiplying the daily rate times the number of calendar days late, times the dollar amount paid. The interest should be included with the claim payment except as noted below.

Measuring Timeliness and Accuracy *(cont'd.)*

Interest Accuracy *(cont'd.)*

Commercial *(cont'd.)*

To avoid a mandated $10.00 per claim penalty, the full amount of interest warranted must be paid "automatically." "Automatically" means that the interest must be included with the claim payment or mailed within five working days of the original claim payment. If the warranted amount of interest is underpaid, the mandated $10.00 per claim penalty must be paid along with the additional interest due.

If the interest amount is less than $2.00 the interest may be paid on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid as long as a statement identifying the specific claims for which the interest being paid is included.

For claims involving emergency services, the minimum amount of interest due is the greater of either $15.00 for each 12-month period or 15 percent per annum calculated as described above.

Medicare Advantage

Clean claims from unaffiliated/non-contracted providers paid later than the statutory deadline requires interest to be paid. Interest is to be calculated beginning on the thirty-first calendar day through the day the check is mailed.

Interest is due at the current Federal Prompt Payment Interest Rate, which is updated each January and July. The current interest rate can be found at www.fiscal.treasury.gov/prompt-payment/rates.html.

Interest is to be calculated based on 1) the number of calendar days over thirty (30), 2) the current Medicare interest rate and, (3) the amount paid. The daily rate is the result of dividing the interest rate in effect at the time the claim was paid by 365 or 366 in the case of a leap year.

The amount of interest is calculated by multiplying the daily rate, times the number of calendar days over 30, times the dollar amount paid. The interest should be included with the claim payment.

Measuring Timeliness and Accuracy *(cont'd.)*

Measuring Timeliness

Commercial Claims

Claim processing begins when a claim is first delivered to delegated payor's office. The number of days measured are "working" days. The time limit to make payment – 45 working days – applies to all claims, without regard to whether the billing providers are contracted or non-contracted. If a claim is to be contested the notice to that effect must be mailed within 45 working days.

If a Management Service Organization (MSO), that manages several delegated entities, receives a claim from one of their post office boxes and loads the claim into the wrong Delegated Entity's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity's claim system.

Member-denial notices must be mailed within 30 calendar days of receipt of the claim to fulfill the ERISA regulations. This policy blends requirements from ERISA regulations and California's Health and Safety Code. To fulfill the state regulations all denial notices must be mailed within 45 working days.

Commercial Provider Dispute Resolution (PDR)

Resolution and a written determination must be completed within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.

If the provider dispute is overturned in favor of the provider, payment is due within five (5) working days of the issuance of the written determination. If the payment is issued prior to the written determination, the written determination is due to the provider within five (5) working days of the issuance of the payment. Interest and penalties on disputes which result in determination in favor of the provider, should be calculated beginning 45 working days following the date of receipt of the original complete claim.

Measuring Timeliness and Accuracy *(cont'd.)*

Measuring Timeliness *(cont'd.)*

Medicare Advantage Claims

Claim processing begins when a claim is received anywhere within a health plan if the claim was received first by the plan's contracted network, contracted clearing house and/or imaging vendor, or post office box of either of the health plan or contracted network. If a Management Service Organization (MSO), that manages several delegated entities, receives a claim from one of their post office boxes and loads the claim into the wrong Delegated Entity's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity's claim system The earliest date stamp on a claim determines when the timeliness cycle begins and must be entered into the claim system as the received date unless documentation can be provided to validate that the earliest stamp(s) does not belong to the Blue Shield contracted network. The number of days measured is "calendar" days. There are two different types of claims, each with its own processing time limit: 1) 30 calendar days for clean claims from unaffiliated/ non-contracted providers and 2) 60 calendar days for all other claims – "unclean" claims paid or denied from unaffiliated/non contracted providers, or claims paid or denied from affiliated/contracted providers. The mailed date of the check and/or correspondence defines the end of the claim's turnaround time.

Medicare Advantage Provider Dispute Resolution (PDR) for Non-Contracted Provider

Provider dispute resolution includes decisions where a non-contracted provider contends that the amount paid by the payor for a covered service is less than the amount that would have been paid under Original Medicare. Submission of a first level Provider Dispute must be filed within a minimum of 120 calendar days after the notice of initial determination. Resolution and a written determination must be completed within 60 calendar days after the date of receipt of the provider dispute. The non-contracted provider may submit a second level written request to Blue Shield within 180 calendar days of written notice from the payor. Second level disputes must be submitted to:

Blue Shield of California Provider Dispute Resolution Office
Attn: Medicare Advantage
P.O. Box 272640
Chico, CA 95927-2620

The provider payment dispute process cannot be used to challenge denials by organizations that result in zero payment being made to the non-contracted provider. The payment dispute process may not be used to resolve payment disputes between contracted network providers and organizations covered by this process.

Measuring Timeliness and Accuracy *(cont'd.)*

Commercial Evidence of Payment (EOP)/Remittance Advice (RA)

Each Delegated Entity needs to include the following information in their EOP/RA:

- PDR Verbiage

  California Code of Regulations, Title 28 Section 1300.7138 (b)

  - (b) Notice to Provider of Dispute Resolution Mechanism(s). Whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address for a filing a provider dispute.
  - The right to dispute a claim using the approved PDR request form.
  - The dispute must be submitted within 365 calendar days from last claim action.
  - Written determination of the dispute must be made consistent with applicable state and federal law, within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
  - A provider has the right to submit an appeal if they do not agree with this resolution of this claims dispute. The language should include "you have the right to appeal directly to Blue Shield of California within 60 working days from the Date of Determination." This appeal would only be for Medical Necessity *de novo* review.

    Please submit to the following address:

    Blue Shield of California Provider Dispute Resolution Office
    P.O. Box 272620
    Chico, CA 95927-2620

Measuring Timeliness and Accuracy *(cont'd.)*

Medicare Evidence of Payment (EOP)/Remittance Advice (RA)

Each Delegated Entity needs to include the following information in their EOP/RA:

- Denial Rights
- Waiver of Liability Statement
    - The Waiver of Liability statement can be downloaded from the CMS website at www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip
    - Per CMS, Delegated Entities cannot provide a link to the CMS web page and give the non-contracted provider the instructions to access the form
    - The EOP should have the waiver of liability link referenced above OR
    - Waiver of Liability link and form together

      Note: Delegated Entities CANNOT have the form only.
- Appeal Rights
- PDR Second Level Verbiage
    - "You have the right to dispute this decision directly with Blue Shield of California within 180 days from the determination of the payer."

Measuring Timeliness and Accuracy *(cont'd.)*

Member Denial Notice

Commercial

A denied claim is a claim where (1) one or more services will not be paid by the Delegated Entity's claims operation and (2) payment is the financial responsibility of the member.

Member denied claims are reported and monitored separately from paid and "contested" claims. Provider-denials are reported and audited along with other contested claims.

Examples of claims that are not member-denials and should not be reported, submitted, or presented to Blue Shield as member liability "denied" claims include:

- Patients who remain enrolled with the health plan but have transferred from one Delegated Entity to another must be forwarded to the health plan or the other entity for processing;
- Duplicates to claims already paid or denied must be denied as duplicates, a second denial notice may not be mailed to the member;
- Encounter only and capitated claims;
- Denials to a contracting provider who must write off the unpaid claim (unless the provider has written evidence that the member understood and accepted payment responsibility); or
- Reduced payment amounts due to contract terms, or correction of billing errors such as bundling or inaccurate coding

Measuring Timeliness and Accuracy *(cont'd.)*

Member Denial Notice *(cont'd.)*

Medicare Advantage

A denied claim is a claim where (1) one or more services will not be paid by the provider claims operation and (2) payment is the financial responsibility of the member.

Examples of claims that are not member-denials and should not be reported, submitted, or presented to the health plan as member liability "denied" claims include:

- Patients who remain enrolled with the health plan but have transferred from one
- Delegated Entity to another and you are just forwarding the claim to the health plan or the other entity for processing;
- Patients who remain capitated to your organization, but payment responsibility belongs to another contracting entity (health plan or hospital), and you are forwarding the claim;
- Duplicates to claims already paid or denied;
- Encounter only and capitated claims;
- Denials to a contracting provider who must write off the unpaid claim (unless the provider has written evidence that the member understood and accepted payment responsibility); or
- Correction of billing errors such as bundling or inaccurate coding.

Member Denial Notice - Standards

Commercial

When health plans and Delegated Entities make decisions to deny claims that result in liability for the enrollee, those decisions must be in accordance with DMHC and DOL law and regulations (ERISA), including required coverage for emergency care taking the "reasonable person" standard into account. The member must be given clear information including phone numbers and mailing addresses to assist them in contacting the health plan or the delegated claim operations or the consumer assistance agencies for more information or to appeal the denial decision.

Once a denial notice has been sent, no further adverse notices may be sent to the member.

All member emergency and non-emergency denial letters must include the denial code and denial reason. The denial reason code should match what is being submitted on the EOB/RA.

Measuring Timeliness and Accuracy *(cont'd.)*

Member Denial Notice - Standards *(cont'd.)*

Commercial *(cont'd.)*

Denial letters sent to members should include Section 1557 of the Affordable Care Act of 2010 which prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities. Members must be notified about their rights under Section 1557. Specifically, delegated entities must include a nondiscrimination notice in English and taglines in at least the top 15 non-English languages spoken by individuals with limited English proficiency with every member liability denial notice.

Medicare Advantage

Federal law, regulations and CMS guidelines govern initial coverage determinations that are adverse to a Medicare beneficiary (i.e., denials that result in financial liability for the beneficiary).

These requirements apply to health plans and thereby to any entity in which authority to make coverage determinations has been delegated. When an adverse determination has been made, the current CMS approved Integrated Denial Notice (IDN) letter format must be sent to the member.

Any changes to Integrated Denial Notices will be sent out annually as applicable.

Each IDN letter should include Section 1557 of the Affordable Care Act of 2010 which prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities. Members must be notified about their rights under Section 1557. Specifically, covered entities must include a nondiscrimination notice in English and taglines in at least the top 15 non-English languages spoken by individuals with limited English proficiency with every Integrated Denial Notice.

All Integrated Denial Notices (IDN) must contain the Blue Shield Medicare Advantage plan CMS material identification number along with the CMS-approved expiration date. The most current IDN letter may be obtained through the Blue Shield's Delegated Claims Oversight department.

If identified that the member is eligible with a Blue Shield but assigned to another Delegated Entity, the claim must be forwarded to the appropriate payor or denied to the provider of service informing them that another payor is responsible. It is not a member's liability.

Measuring Timeliness and Accuracy *(cont'd.)*

Member Denial Notice - Standards *(cont'd.)*

Medicare Advantage - Opt Out

Any provider that has chosen not to participate with the CMS Medicare program may not provide services to Medicare members without notifying the member in advance that they have elected to opt out of the CMS Medicare program. Upon advanced notification, the member would be responsible for the payment of the services rendered.

Overpayment

Commercial

The Delegated Entity has a total of 365 calendar days from the date of payment to initiate an overpayment request. The request must be in writing and allow the provider of service a minimum of 30 working days to contest and/or refund the overpayment. The Delegated Entity may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission when (1) the provider fails to reimburse within the 30-working day timeframe and (2) the provider has entered into a written contract specifically authorizing the Delegated Entity to offset an uncontested notice of overpayment of a claim from the contracted provider's current claims submissions.

Medicare Advantage

The Delegated Entity may go back three (3) years from the date the claim was paid to collect an overpayment. Once an overpayment is discovered and a final determination is made, a first written demand letter is sent. If a full payment is not received within 30 calendar days interest accrues starting on day 31. If the provider agrees with the overpayment by day 15, recoupment can start if the provider sends a rebuttal follow the Medicare process. If the Delegated Entity has a written agreement with the provider to automatically off-set any overpayment(s) no written demand letter is required.

Payment Accuracy

Commercial

Payment accuracy includes: (1) proper payment of interest, (2) proper use of a reasonable and customary fee schedule for non-contracted providers, (3) applying appropriate contract fee schedules, and (4) system configuration. All four criteria must be met for a claim or a claim provider dispute to be considered compliant in payment accuracy.

Medicare Advantage

Payment accuracy includes: (1) proper payment of interest and (2) proper use of provider fee schedules for non-contracted providers, and (3) system configuration. The three criteria must be met for a claim or a claim provider dispute to be considered compliant in payment accuracy.

Measuring Timeliness and Accuracy *(cont'd.)*

Rescinding Authorization- AB 1324 (Health & Safety Code Section 1371.8)

Blue Shield validates that Delegated Entities pay incurred services if the specific service was pre-authorized or referred, even if the member is later found to be ineligible for any reason, when the provider of service relied on the authorization or referral in good faith and validated the eligibility of the member prior to the service being rendered. If the Delegated Entity has an approved authorization and service has not been rendered, the Delegated Entity needs to formally rescind the authorization by sending a notice to the authorized rendering provider and to the member. The Delegated Entity can bill Blue Shield under the eligibility guarantee clause within their contract with Blue Shield if services were rendered by a provider who relied on the authorization in good faith.

Timely Filing

Commercial

The Department of Managed Health Care enacted regulations related to claims settlement and dispute resolution practices of health plans and their delegated hospitals ("AB 1455 Regulations"). Among other things, the AB 1455 Regulations provide timely filing limitations for commercial claims depending on the provider's status. Timeframes for filing claims for contracted and non-contracted providers are as follows:

- Contracted – A deadline of less than ninety (90) days after the date of service may not be imposed.
- Non-contracted – A deadline of less than one hundred eighty (180) days after the date of service may not be imposed

Medicare Advantage

- Claims with dates of service January 1, 2010, and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

Medicare Advantage Provider Dispute Resolution (PDR)/Appeal

The submission of a first level provider dispute/appeal must be filed within a minimum of 120 calendar days after the notice of initial determination (i.e., explanation of benefits, remittance advice, and/or letters). Additional filing requirements are as follows:

- The payor may allow an additional 5 calendar days for mail delivery
- The payor may extend the time limit for filing a provider dispute/appeal if good cause is shown

Measuring Timeliness and Accuracy *(cont'd.)*

Unclean or Contested Claims (Affiliated or Unaffiliated Providers)

Commercial (Contested)

The Delegated Entity may contest incomplete claims that are missing information. The claim may either be pended and/or contested to the provider and may include a statement that it will receive no further attention if no reply is received. Contested claims are not to be reported as member-denials. The contested or pended claims must be closed prior to the 45th working day. No denial notice should be sent to a member when "closing" a claim pending receipt of additional information.

Medicare Advantage (Unclean)

For Medicare Advantage claims, two separate attempts are recommended to obtain missing information, allowing sufficient time for the provider to respond to each request and indicating the claim will be denied by the 60th calendar day if no response is received. By the 55th calendar day post receipt of the claim an initial determination to pay or deny the claim must be made based on the information available.

Best Practices and Claims Adjudication

In this section as well as prior sections, the terms "our" or "your" refer both to health plans and to the Delegated Entity. Best practices are recommended for everyone involved in claims processing. When the word "must" is used, Blue Shield regards the standard as the requirement to be met.

Audits and Audit Preparation

Blue Shield, CMS, and the DMHC will conduct periodic audits of claims and provider disputes (where appropriate) to ensure compliance with all regulatory requirements. In advance of Blue Shield's audit, Blue Shield will send a written notification 60 days prior to audit that includes the documents the Delegated Entity will need to provide along with the scope of the audit and due dates of when the material needs to be submitted. The documentation includes providing claims universes for each category. An industry standard questionnaire will need to be completed that will provide detailed information about your claims processing operations and internal controls. Also provided is a cover sheet that needs to be completed and attached to each claim sample. Note that the claim sample must include the following documentation from the contract with the provider: the first and last page (signature) and rate sheet. All documentation is required to be submitted with sample claim as noted on the cover sheet.

Best Practices and Claims Adjudication *(cont'd.)*

Audits and Audit Preparation *(cont'd.)*

Blue Shield will perform an annual audit for claims and compliance oversight which include internal controls and IT system security. Blue Shield will provide a notification of the annual audit that includes the scope of the audit along with interviews of appropriate departments within the Delegated Entity's organization. Blue Shield will require a walk through and demonstration of the Delegated Entity's operations. This will include a demonstration of the life of a claim from end to end (mailroom to disposition of payment and/or denial) which will include operational systems and interviews of staff associated with specific functional areas. To assure end to end processes are formally documented, Blue Shield requires submission of Policy and Procedures (P&P) noted in the industry standard questionnaire as well as P&Ps requested during the audit claims assessment questions interview on the scheduled audit day. As part of the assessment, Blue Shield evaluates that P&Ps are reviewed annually via evidence that they were approved via committee or appropriate authority signature and dated.

If required claims documentation is not received, the audit is incomplete and will be scored as non-compliant and a corrective action plan (CAP) will be required by the Delegated Entity along with a follow up audit that will be scheduled. The Delegated Entity will be escalated to the Delegation Oversight Committee as non-compliant for lack of submission of audit documents. Electronic submission of all data is required.

Blue Shield will provide the Delegated Entity with written results within 30 calendar days including an itemization of any deficiencies and whether or not the Delegated Entity must prepare and submit a formal, written corrective action plan to include root cause and remediation within 30 days of receipt of audit results or provide additional supporting documentation within time period provided by Blue Shield.

Regulatory Audit

In the event CMS or the DMHC require that Blue Shield conduct additional compliance oversight, Blue Shield will require the Delegated Entity to participate within the regulator-specified time schedules or deadlines and provide the material in the format requested in the timeframe as stipulated by the regulators. Refusal to do so will result in an escalation to the Delegation Oversight Committee.

Best Practices and Claims Adjudication *(cont'd.)*

Balance Billing

Commercial

California state law prohibits balance billing by contracted providers for all services and non-contracted providers of emergency services.

The California Code of Regulations identifies in Title 28 Section 1300.71 (g) (4) that every plan contract with a provider shall include a provision stating that except for applicable copayments and deductibles, a provider shall not invoice, or balance bill a plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the plan or the plan's capitated provider for any covered benefit.

Except for services subject to the requirements of Section 1367.11 of the Act, "unfair billing pattern" includes balance billing by an emergency services provider. If the provider continuously balance bills the member, the Delegated Entity should submit all written and documented verbal communication with the provider to the health plan who will report the provider to the Department of Managed Health Care (DMHC) for further action by the state. A non-contracted provider may appeal to the health plan directly should they disagree with the payment from the Delegated Entity.

AB 72

AB 72 (Health & Safety Code Section 1300.71.31. Methodology for Determining Average Contracted Rate; Default Reimbursement Rate) establishes a payment rate, which is the greater of the average of a health care service plan (health plan) or Delegated Entity contract rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services. The Delegated Entity must participate in the Independent Dispute Review Process (IDRP) and provide Blue Shield with the contact information to provide to the IDRP contractor managed by DMHC.

If the Delegated Entity fails to meet required timeframes for claims payment and Blue Shield determines that the claim is payable by the Delegated Entity, Blue Shield may pay the claim and deduct the amount of the payment from future capitation. When this occurs, Blue Shield will provide documentation explaining the deduction.

Medicare Advantage

Chapter 4 of the *Medicare Managed Care Manual,* Benefits and Beneficiary Protections, addresses when beneficiaries may be balanced billed, as identified below.

Best Practices and Claim Adjudication *(cont'd.)*

Balance Billing *(cont'd.)*

- Contracted providers are prohibited from balance billing enrollees. They may only collect the copayments and/or coinsurance.
- Non-contracting participating providers are prohibited from balance billing enrollees. They may only collect the copayments and/or coinsurance.
- Non-contracted non-participating providers can balance bill the health plan up to the original Medicare limiting charge.
- Non-contracted non-participating DME suppliers can balance bill the health plan the difference between the member's cost sharing and the DME supplier's bill.

Corrective Action/Follow Up Audits

Blue Shield performs, at a minimum, an annual claims and PDR audit. Follow-up audits will be scheduled by the assigned auditor if the Delegated Entity fails the annual audit. If applicable, as a result of a non-compliant follow-up audit, additional monitoring and/or remediation validation audits will be performed based upon outcome of escalation to the Delegation Oversight Committee. For those Delegated Entities who are subject to DMHC audits, if deficiencies are determined during the review, a corrective action plan (CAP) is required to be sent to Blue Shield by the date provided by the auditor. Additionally, Blue Shield may perform an unannounced audit dependent upon other indicators.

Date Stamping

Delegated Entities must date stamp all paper claims, including facsimiles, with the date the claim was received. The stamp should identify the specific Delegated Entity. Blue Shield recommends that each page of the paper claim including any attachments be date stamped. If a paper claim is received and then scanned for audit purposes, it should be batched for scanning by the original received date and include a unique identifier of the received date on the image.

For Medicare Advantage claims, federal procedures suggest that claims received from the U.S. Postal Service after 4:30 PM may be considered "received" on the next business day. If a courier picks up the claims from the post office and transports them to the Delegated Entity's claims office, the time of pickup by the courier is what determines the date of receipt. The earliest received date by any Blue Shield Medicare Advantage HMO and PPO network provider must be utilized for Medicare Advantage claims.

For Commercial claims, date of receipt means the working day when a claim, by physical or electronic means, is first delivered to the Delegated Entity's post office box, claims office or subcontractor who is responsible for receipt and processing of claims mail. The claims receipt date can also be the date the Delegated Entity receives a claim forwarded to them by either physical or electronic submission as they have been determined to be the correct payor.

Best Practices and Claim Adjudication *(cont'd.)*

Disbursement of Payments

The date of payment is the date that the funds were electronically transferred (EFT) or the date the check was mailed via postal service to the provider. Blue Shield validates the EFT date as well as the date the payment was mailed. It is recommended that the Delegated Entity does not exceed 3 days from the paid date to the mail date. The additional mail processing days will be added into the claim's turnaround time calculation. Blue Shield will use the check mailed date as the closure of the claim's turnaround time. The Delegated Entity must provide a mail date policy and procedure to verify the additional days have been included to validate turnaround time for audits.

Emergency Claims

The Emergency Medical Treatment and Labor Act (EMTALA) is an accepted standard in the health care industry that applies to emergency medical care. The EMTALA provides protection to consumers from high medical costs that may arise from emergency situations. This standard requires insurance companies to provide coverage for emergency care based on symptoms, not the final diagnosis. This is speaking to payment of a claim versus denial.

Care for issues that may be chronic or blatantly non-emergent generally do not fall into qualifying for immediate treatment under the prudent layperson standard and would generally be considered as non-emergent conditions. These can be such cases as:

- Normal follow-up of a medical condition.
- Removal of stitches.
- Medication refills.

"***Prudent Layperson***" is described as:

- A person who is without medical training and who draws on their practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought.
- A person with an average knowledge of health and medicine.

Best Practices and Claim Adjudication *(cont'd.)*

Emergency Claims *(cont'd.)*

The California Department of Managed Health Care (DMHC) provided guidance regarding when emergency services provided to an enrollee must be reimbursed as per the Knox-Keene Act Standard lastly in APL 17-017 which cited:

- Health and Safety Code § 1371.4 (b): A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.
- Health and Safety Code § 1371.4 (c): Payment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.
- Health and Safety Code § 1317.1 (b): An Emergency Medical Condition which is defined as a medical or mental health condition (and/or substance use disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
    - Placing the patient's health in serious jeopardy.
    - Serious impairment to bodily functions.
    - Serious dysfunction of any bodily organ or part.

Best Practices and Claim Adjudication *(cont'd.)*

Emergency Claims *(cont'd.)*

Examples of such conditions could be but are not limited to:

- Loss of consciousness
- Seizure
- Chest pain
- Trouble Breathing
- Choking
- Severe pain
- Suicidal ideations
- Overdose

The standard articulated by the Knox-Keene Act in Section 1371.4 and 1371.5 turns on whether the enrollee him/herself reasonably believed he/she had an emergency medical condition. This standard is not the objective "reasonable person" or "prudent layperson" standard that asks whether a reasonable person would have believed a medical emergency existed. Rather, the Knox-Keene Act's standard is subjective and takes into consideration whether the enrollee's belief was reasonable given the enrollee's age, personality, education, background, and other similar factors.

Please note that whether the enrollee believed he/she was experiencing a medical emergency may not always be evident from the medical record of the visit because the records may not capture the mindset of the patient when he/she presented at the emergency room.

Best Practices and Claim Adjudication *(cont'd.)*

SB 855

Senate Bill 855 requires plans, for level of care determinations, to use treatment criteria developed by the non-profit, clinical professional association of the relevant clinical specialty. This is spelled out in Health and Safety Code Section 1374.721 (b) which states:

Effective January 1, 2021, in conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, pursuant to this section, plans must apply criteria and guidelines set forth in the "most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty."

These associations are listed on Attachment A of APL 21-002 dated January 5, 2021.

- Substance Abuse Disorder, any age – American Society of Addiction Medicine (ASAM).
- Mental Health Disorders, patients 18 and over – American Association of Community Psychiatrists.
- Mental Health Disorders, patients 6 to 17 years of age - American Association of Community Psychiatrists OR American Academy of Child & Adolescent Psychiatry.
- Mental Health Disorders, patients 0 to 5 years of age - American Academy of Child & Adolescent Psychiatry.
- Gender Dysphoria – World Professional Association for Transgender Health (WPATH).

Forwarding Claims (Misdirected for Commercial and Medicare Advantage)

Billing providers often submit claims and disputes to the incorrect payor. It is a requirement that the Delegated Entity to forward these claims and disputes directly to the financially responsible entity, if known, otherwise deny with a remit message informing the provider the Delegated Entity is financially responsible for processing of the claim.

The misdirected claim's original received date is used to determine timeliness based upon how the claim was received first by the Delegated Entity's contracted clearing house(s) and/or imaging vendor(s), and/or post office boxes it owns.

If a Management Service Organization (MSO), that manages several Delegated Entities, receives a claim from one of their post office boxes and it loads the claim into the wrong Delegated Entity's claims system the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity's claim system.

Commercial Forwarding Timeliness

Regulations require the Delegated Entity to forward misdirected claims to the responsible payor within ten (10) working days of receipt.

Best Practices and Claims Adjudication *(cont'd.)*

Forwarding Claims (Misdirected for Commercial and Medicare Advantage) *(cont'd.)*

Medicare Advantage Forwarding Timeliness

The misdirected claim's, original received date is used to determine timeliness if the claim was received first by the plan contracted network, contracted clearing houses and/or imaging vendors, post office boxes of either health plans or contracted network.

Health plans and Delegated Entities should forward claims within ten (10) calendar days of initial receipt.

Monitoring of a Subcontractor (this includes MSO) for a Delegated Function-Offshore/Onshore

When the Delegated Entity engages a third-party administrator (TPA) or contracts with a management company to perform their claims processing, the Delegated Entity's contract with Blue Shield holds them ultimately responsible for claims compliance. Guidelines for sub-delegated functions are interchangeable within this section.

The Delegated Entity is expected to require the sub-delegated claims organization to meet all regulatory requirements and criteria discussed in this supplement. The Delegated Entity must perform the same tasks, e.g., delegation oversight of claims processing, that Blue Shield carries out as the Health Plan, including obtaining timely monthly reporting from them, and include their statistics in the Delegated Entities reports to Blue Shield. The Delegated Entity must audit the sub-delegated organization annually/periodically and require corrective action plan implementation when their performance results are not compliant. If the sub-delegated organization fails to achieve compliance the Delegated Entity needs to take the appropriate actions to achieve compliance. If the Delegated Entity sub-delegates claims functions, they will need to demonstrate and provide evidence of their oversight of that entity during the on-site audit. If the Delegated Entity outsources claims functions that will also need to be monitored.

The Delegated Entity must include claims-related regulatory and contractual provisions in contract agreements with other provider organizations.

The regulators require all health plans and their contracted delegated entities to demonstrate oversight and monitoring of any subcontractor that has sub delegated operational functions that otherwise are audited by a health plan. "Subcontractor" refers to any organization that a sponsor contracts with to fulfill, or help fulfill, requirements of a delegated function. The term "offshore" refers to any country that is not one of the fifty United States or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). In providing oversight, Blue Shield requires all Delegated Entities to submit an annual offshore attestation and proof of an annual audit conducted on the offshore and/or onshore subcontractor. If the commercial line of business is offshored, approval is required from Blue Shield prior to offshoring any Blue Shield commercial delegated claims.

Best Practices and Claim Adjudication *(cont'd.)*

Reopenings

A reopening is a remedial action taken to change a binding determination or decision that resulted in either overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process.

Reopenings are different from adjustment claims in that adjustment claims are subject to normal claims processing timely filing requirements (that is, filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (e.g., claim determinations may be reopened within one year of the date of the initial determination for any reason, or within one to four years of the date of the initial determination upon a showing of good cause).

Reference Materials for Reopenings

- 42 CFR 405.980
- MLN Matters Number SE 1426
- Medicare Manual Chapter 34
- Medicare Managed Care Manual Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance
- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912
- www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/ORGDetermin

Reporting

Claims Reports

Monthly/Quarterly self-reports must be submitted on the ICE industry-standard templates. Report templates and detailed instructions can be found in this appendix under the *Claims Delegate Reporting Instructions* section.

Compliance Program Effectiveness Oversight Audit

Delegation Oversight will perform an annual audit of the effectiveness of your organization's Compliance Program. The audit includes the assessment of the following:

- Compliance Program structure (the effectiveness of your organization's compliance program.
- Risk Bearing Organization (RBO) and Management Services Organization (MSO) ownership and hours of availability
- Training material and the training your organization conducts on all employees (including temporary and contracted employees)
- Implemented policies and procedures
- FWA reporting
- Monitoring and auditing internal risks
- Organization's internal controls and organization capacity structure

This audit will be performed either via Blue Shield Delegation Oversight Compliance Team individually on an annual basis or as a shared audit through HICE (Health Industry Collaborative Effort).

The Compliance audit evidence grid will be provided by the Delegation Oversight Auditor prior to the scheduled audit date. The grid should be used as a guide for audit documentation submission guidelines and as well as policy and business rules to assist with understanding the audit history and requirements. To download a copy of the Compliance Audit Evidence Grid, go to the Blue Shield provider website at www.blueshieldca.com/en/bsp/providers and navigate to the *Forms* section, then *Delegation oversight forms*. All requested documents from the evidence grid must be submitted to BSCandPHP_DOCPEAudit@blueshieldca.com.

For more information on the shared audit process and joining, please visit the HICE website at www.iceforhealth.org/teamactivities.asp.

Fraud

Fraud is the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s). An example of fraud is when a provider purposely bills for services that were never given or bills for a service that has a higher reimbursement than the service provided.

Compliance Program Effectiveness Oversight Audit *(cont'd.)*

Abuse

Abuse includes, but is not limited to the following improper behaviors or billing practices:

- Billing for a non-covered service;
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered);
- Inappropriate allocating costs on a cost report; or
- Payment for items or services that are billed by mistake by providers but should not be paid for by Medicare. This is not the same as fraud.

Compliance Program

Key components of a strong compliance program should include but are not limited to:

1. Written policies, procedures, and standards of conduct articulating the organization's commitment to comply with all applicable federal and state standards.
2. The designation of a compliance officer and compliance committee accountable to senior management.
3. Procedures for conducting claims compliance/internal control audits.
4. The procedures that will be taken to report the suspected fraud to Blue Shield.
5. Effective training and education between the compliance officer and the employees, managers, directors, and the downstream and related entities.
6. Effective lines of communication between the compliance officer, members of the compliance committee, the employees, managers and directors, and the downstream and related entities.
7. Enforcement of standards through well-publicized disciplinary guidelines.
8. Procedures for effective internal monitoring and auditing.
9. Procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives relating to the organization's contract.
10. Respond to and initiate corrective action to prevent similar offenses including a timely responsible inquiry.
11. Conduct timely and reasonable inquiries.
12. Conduct appropriate corrective actions in response to the potential violation.
13. Include procedures to voluntarily self-report potential fraud or misconduct to the health plan, state, and federal regulators.

Compliance Program Effectiveness Oversight Audit *(cont'd.)*

Compliance Program *(cont'd.)*

14. Development and implementation of regular, effective education, and training that occurs annually.
15. Retain records of the annual training of employees, including attendance logs and material distributed at training sessions.
16. Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded or precluded from participating in CMS programs.
17. Include a system to receive, record, and responds to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality. The Delegated Entity will report compliance concerns and suspected or actual misconduct without retaliation when reporting in good faith to Blue Shield.
18. Policy shall allow any state, federal government, or CMS to conduct on-site audits.
19. Performance of data analysis of procedures codes, diagnostic codes, utilization, quantity, etc., to detect fraud.
20. Ensure program includes the monitoring of claims for accuracy which includes ensuring coding reflects services provided.
21. Be able to produce proof to show compliance with all requirements.
22. Check the Office of Inspector General (OIG) and the General Services Administration (GSA) exclusion lists for all new employees and on a regular basis or at least once a year thereafter to validate that employees and other entities that assist in the administration or delivery of services are not included on such lists.
23. Check the Office of Inspector General (OIG) and the General Services Administration (GSA) exclusion lists for all providers on a regular basis to validate that the providers that assist in the administration or delivery of services are not included on such lists.

Compliance Program Effectiveness Oversight Audit *(cont'd.)*

Reporting

Please use one of the following ways to report fraud, waste, and abuse to Blue Shield:

- Call the Blue Shield 24-hour Anti-Fraud Hotline at (800) 221-2367. This hotline is managed by Blue Shield's Special Investigations Unit.
- Send an email to MedicareStopFraud@blueshieldca.com.
- Submit an inquiry via the internet at www.blueshieldca.com/memberwebapp/fraud-report.

CMS and DMHC mandates that each health plan and its Delegated Entities have a Fraud, Waste, and Abuse program in place and further mandates that all employees are required to take the training, at a minimum, annually. To ensure Blue Shield is meeting all CMS and DMHC requirements, Delegated Compliance Oversight will perform annual review of each Delegated Entity's Compliance Program, including a Fraud, Waste, and Abuse program and assurance that all employees have taken Compliance Program training.

IT System Security

An IT system integrity audit will be conducted to assure system access controls, policy and procedures regarding system changes, security of data, etc. are maintained. The oversight is also performed either via shared audit through HICE or individually on a bi-annual basis with quarterly monitoring. Areas of overall concern to be reviewed include:

- Operational effectiveness
- Access to programs and data access rights definition
- Access to programs and data access control mechanisms and password complexity
- Program changes/standard change management
- Computer operations (backup, recovery, and resumption)/HIPAA compliance
- Program changes
- Access to IT privileged functions

Oversight Monitoring

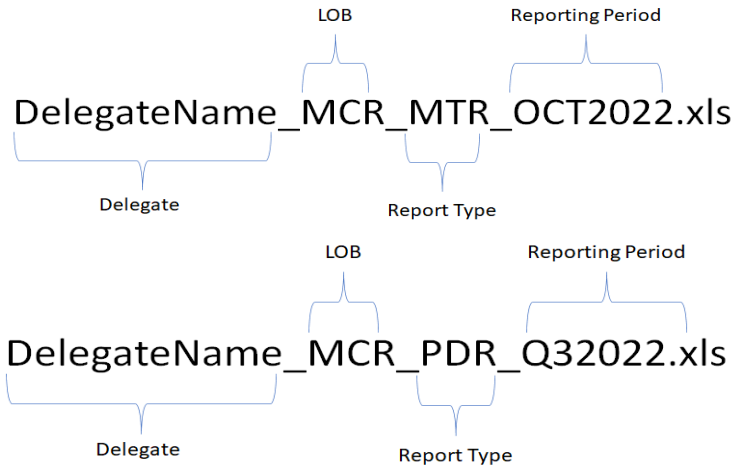
Delegated Entity shall implement controls to ensure internal processes are monitored for integrity of mechanisms and procedures to promote accountability and prevent fraud.

- Group shall not allow the same person or departments to have the ability to pay claims and enter or update new providers, vendors, and/or eligibility;
- Group shall provide staffing levels and organizational capacity to ensure operations are consistent and maintained at all times;
- Group shall maintain a compliance program, and that the program is independent of fiscal and administrative management;
- Group shall ensure personnel have appropriate access to data, consistent with their job requirements; and
- Group shall ensure that any and all changes made to data contained in entities; databases are logged and audited.

Claims Delegate Reporting Instructions

Please email reports to the following contacts:

Report Submission	
Submit Reports To:	ClaimsDelegateReport@blueshieldca.com
Report Template:	Submit results using Blue Shield of CA or BSC Promise report template.
Report Format:	If submitting an Adobe PDF in order to satisfy the Designated Principal Officer signature requirements, please also submit the report on the original Excel template.

Report Naming Convention	
	
Delegate	The delegated entity's name or an acronym which represents the group.
LOB	COMM (Commercial) MCR (Medicare) MCL (Medi-Cal) CMC (Cal Medi-Connect)
Report Type	DECD (Disclosure of Emerging Claim Deficiencies MTR (Monthly Timeliness Reporting) PDR (Provider Dispute Resolution) POF (Principal Officer Form)
Reporting Period	Identify the period being reported on e.g., OCT2022, Q32022, etc.

Designated Principal Officer	
Who Can Sign:	Results for the quarter must be attested to/signed by a Designated Principal Officer. The person attesting to the accuracy and completeness of the report must be an executive of the organization, Vice President level of above.

Claims Delegate Reporting Instructions *(cont'd.)*

Reports

Review all the Monthly/Quarterly report requirements. Please submit the Excel/Word report in addition to the signed document. Reports that do not meet reporting standards or have issues will be returned with a request to correct the inconsistencies. Prompt submission is expected to ensure timely reporting.

1. Disclosure of Emerging Claim Deficiencies

In accordance with the California Code Regulation (Title 28, Section 1300.71-Claims Settlement Practices), delegated entities that report claims deficiencies, must complete a Disclosures of Emerging Claims Payment Deficiencies form. The delegated entity will identify the reason for such reported deficiencies by selecting series of check mark boxes, which explain the lack or thereof compliance during the reporting period.

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Commercial	Claims Settlement Practice reports are submitted quarterly. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 30th • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year.	Blue Shield Provider Connection under *Delegation oversight forms*

Claims Delegate Reporting Instructions *(cont'd.)*

2. Monthly Timeliness Report (MTR) (Commercial)

Claims must be processed within 45 working days.

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Commercial	Reports are submitted monthly. The reports are due by the 15th of the month following the end of the reported month. If the 15th of the month falls on a weekend or holiday, the reports are due the next business day. At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • January report due February 15th • February report due March 15th • Q1 report due April 31st • April report due May 15th • May report due June 15th • Q2 report due July 31st • July report due August 15th • August report due September 15th • Q3 report due October 31st • Oct report due November 15th • November report due December 15th • Q4 report due January 31st of the following year	Blue Shield Provider Connection under *Delegation oversight forms*

Claims Delegate Reporting Instructions *(cont'd.)*

3. Monthly Timeliness Report (MTR) (Medicare)

Note: CMS Contract Numbers H0504 and H5928 are reported together under Blue Shield.

The Claims Monthly Timeliness Report is designed to report, without duplication, actions completed (i.e., claims finalized during each month). It includes claims finalized during the month being reported. Plans are to report requests for payment and services, as described in the Part C Technical Specifications, for non-contracted providers and enrollee representative. Do not include:

- Adjustments to previously paid claims
- Interest-only payments
- Claims forwarded to the financially responsible entity for payment
- Duplicate claims
- Encounter-only claims for services sub-capitated to other providers, or claims paid solely as a means of allocating capitation (and the member could never be liable for a denial)

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Medicare	Reports are submitted monthly. The reports are due by the 15th of the month following the end of the reported month. If the 15th of the month falls on a weekend or holiday, the reports are due the next business day. At the end of each reporting quarter, submit a report for the full quarter, include the "ClaimSource," "EnrolleeSource" and "ReopeningSource" tabs. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • January report due February 15th • February report due March 15th • Q1 report due April 31st • April report due May 15th • May report due June 15th • Q2 report due July 31st • July report due August 15th • August report due September 15th • Q3 report due October 31st • October report due November 15th • November report due December 15th • Q4 report due January 31st of the following year	Blue Shield Provider Connection under *Delegation oversight forms*

Claims Delegate Reporting Instructions *(cont'd.)*

4. Payment Dispute Resolution (PDR) (Commercial)

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Commercial	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 31st • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year	Blue Shield Provider Connection under *Delegation oversight forms*

5. Payment Dispute Resolution (PDR) (Medicare)

Note: CMS Contract Numbers H0504 and H5928 are reported together under Blue Shield.

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Medicare	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 31st • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year	Blue Shield Provider Connection under *Delegation oversight forms*

Claims Delegate Reporting Instructions *(cont'd.)*

6. Principal Officer Form

The Principal Officer is the president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

Line of Business (LOB)	Due Date	Report Location
All LOBs	Reports are due by the end of September each year (annually). Also, submit updated reports whenever changes occur to Principal Officer(s) at the delegated entity.	Blue Shield Provider Connection under *Delegation oversight forms*

7. Organization Determinations, Appeals, and Grievances (ODAG)

- Include all requests processed as both contract and non-contract provider denied claims and only non-contract provider paid claims.
- Exclude all requests processed as direct member reimbursements, dismissals, duplicate claims, and payment adjustments to claims, reopenings, claims denied for invalid billing codes, denied claims for beneficiaries who are not enrolled on the date of service, withdrawn requests and claims denied due to recoupment of payment.
- Submit payment organization determinations (claims) based on the date the claim was paid, or should have been paid, or the notification date of the denial, or the date the denial notification should have been sent (the date the request was initiated may fall outside of the review period).
- If a claim has more than one line item, include all of the claim's line items in a single row and enter the multiple line items as a single claim.

Line of Business (LOB)	Due Date	Report Location
Medicare	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the 15th of the month following the end of the reported quarter. If the 15th falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 15th • Q2 report due July 15th • Q3 report due October 15th • Q4 report due January 15th of the following year	Blue Shield Provider Connection under *Delegation oversight forms*