Excellus BlueCross BlueShield Participating Provider Manual

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Navigation note:

The F symbol denotes information of special interest to facilities.

Excellus BlueCross BlueShield Participating Provider Manual

1.0 Introduction

1.1 About the Manual

This *Participating Provider Manual* is a reference and source document for physicians and other providers who participate with Excellus BlueCross BlueShield. The manual clarifies and supplements various provisions of a provider's participation agreement. In the event of a conflict between the provisions of this manual and a provider's participation agreement with Excellus BlueCross BlueShield, the participation agreement controls.

The *Participating Provider Manual* contains relevant program policies and procedures with accompanying explanations and exhibits. Excellus BlueCross BlueShield encourages providers to give this document to staff who perform the administrative, billing, and quality assurance functions in their organizations. It is essential that they understand Excellus BlueCross BlueShield's programs and the procedures Excellus BlueCross BlueShield has established for effective implementation and operation. Excellus BlueCross BlueShield updates this manual as needed.

Representatives of the Provider Relations department are also available to provide on-site training at provider offices. For information, visit our website at ExcellusBCBS.com/ProviderStaffTraining, or call Customer Care. (See the *Contact List* in this manual for addresses and telephone numbers.)

1.2 About Excellus BlueCross BlueShield

1.2.1 Health Plan Description

Excellus BlueCross BlueShield, a nonprofit independent licensee of the Blue Cross Blue Shield Association, is part of a family of companies that finances the delivery of vital health care services to approximately two million people across upstate New York. Excellus BlueCross BlueShield provides access to high-quality, affordable health coverage – particularly for the uninsured, underinsured and aged. It also offers valuable health-related resources that members use every day, such as cost-saving prescription drug discounts and member discounts and programs. More information is available on Excellus BlueCross BlueShield's website,

ExcellusBCBS.com/Provider. See the *Administrative Information* section of this manual for information about the website.

As one New York state's largest not-for-profit organizations, Excellus BlueCross BlueShield remains committed to three core principles:

- We exist to ensure, in the communities we serve, that as many people as possible have affordable, dignified access to needed, effective health care services.
- We recognize the need, and our responsibility, to reach out to all segments of the communities we serve, particularly the poor and aged and others who are underserved, to enhance quality of life, including health status.
- We are committed to being a nonprofit health insurer.

1.2.2 Health Plan Responsibilities

In interacting with participating providers, Excellus BlueCross BlueShield's responsibilities are set forth in individual providers' participation agreements.

Below are some of Excellus BlueCross BlueShield's responsibilities:

- Determining enrollment status and eligibility for covered services.
- Arranging for utilization management decision-making that 1) is based only on appropriateness of care and service and existence of coverage; 2) does not specifically reward practitioners or other individuals for issuing denials of coverage or care; and 3) does not offer financial incentives for utilization management decision-makers to encourage decisions that result in underutilization.
- Providing and administering grievance and appeal processes for members and providers, and offering information on how to access the process.
- Promptly paying clean and uncontested claims for covered services to eligible members in accordance with the time frames required by law and inaccordance with the terms of the providers' participation agreements.
- Compensating participating physicians and other providers directly, consistent with the reimbursement methodologies described in participation agreements.
- Maintaining and ensuring access to all appropriate records relating to health plan performance which an authorized representative of the local Department of Social Services, New York State Department of Health or any other authorized governmental agency may require.

1.2.3 Codes of Conduct

Excellus BlueCross BlueShield maintains Codes of Business Conduct (the Codes) prepared with the advice and assistance of legal counsel and approved by the Board of Directors. The Codes are

a formal statement of the corporation's commitment to the standards and rules of ethical business conduct. They apply to employees, directors, officers, contractors and others with whom Excellus BlueCross BlueShield does business. In addition to being committed to upholding the rules set forth in the Codes, Excellus BlueCross BlueShield is committed to conducting all activities in accordance with applicable laws and regulations.

You may obtain a copy of Excellus BlueCross BlueShield's Code of Business Conduct applicable to participating providers on our website, ExcellusBCBS.com/Provider. Select *About Us >Compliance Notices*. You may also request a copy from Customer Care. (See the *Contact List* in this manual for Excellus BlueCross BlueShield addresses and telephone numbers.)

1.2.4 Prohibition on Restricting Provider Discussion with Members

As mandated by New York State Public Health Law, Excellus BlueCross BlueShield will not, by contract, written policy or written procedure, prohibit or restrict any provider from:

- Disclosing to any subscriber, enrollee, patient, designated representative or, where appropriate, prospective enrollee, any information that such provider deems appropriate regarding a condition or a course of treatment of an enrollee including the availability of other therapies, consultations, or tests, or the provisions, terms, or requirements of Excellus BlueCross BlueShield's products as they relate to the enrollee, where applicable, regardless of benefit coverage limitations.
- Filing a complaint or making a report or comment to an appropriate governmental body regarding the policies or practices of Excellus BlueCross BlueShield when the provider believes that the policies or practices have a negative impact on the quality of, or access to, patient care.
- Advocating to Excellus BlueCross BlueShield on behalf of the enrollee for approval or coverage of a particular treatment or for the provision of health care services.

In addition, nothing in Excellus BlueCross BlueShield's agreements with providers is intended to, or shall be deemed to, transfer liability for Excellus BlueCross BlueShield's own acts or omissions, by indemnification or otherwise, to a provider.

1.2.5 Business Continuity

Excellus BlueCross BlueShield is responsible for creating and maintaining business continuity plans for all of its business units. In the event of a business interruption, we have plans designed to allow us to continue operations of critical business functions, such as claims processing, utilization management, and provider relations. We accomplish this in part by:

- Relocating impacted business units to designated recovery locations.
- Using redundant processing capacity at other locations.
- Designing our technology and systems to support the recovery process for critical business functions.

- Using business and technology teams that are responsible for activating and managing the recovery process.
- Adopting a communication plan to ensure that Excellus BlueCross BlueShield employees receive emergency notifications and instructions via a variety of sources, including in-building announcements, telephone contact, toll-free numbers and websites.
- Rehearsing our recovery procedures and testing those procedures on a regular basis.

In the event of a business interruption impacting Excellus BlueCross BlueShield, its communities, and/or key stakeholders, all business units directly or indirectly involved in ensuring notification to providers will assess the impact, develop the message, obtain executive approval and deploy the message to providers. Information may include any claims submission changes including the elimination of referrals and authorization requirements, if necessary, and anticipated changes to the payment cycle. Routine updates will also be available at ExcellusBCBS.com/Provider.

1.3 Health Plan Products

Excellus BlueCross BlueShield offers its members various kinds of health care coverage, ranging from managed care to traditional indemnity, and including Medicare supplemental coverage and Medicare Advantage health benefit programs.

Below are brief definitions of the various types of health benefit programs. At the end of this section of the manual is a chart (*Product Portfolio*) showing which programs fall into which category. Please note that some program types may include parts of more than one category (for example, HSA).

Note: Excellus BlueCross BlueShield also provides administrative services only (ASO) for some employer groups. While the product may carry the same name as one of the commercial products in the *Product Portfolio* at the end of this section, the employer group may modify the benefit design. Example: An employer group may add preauthorization requirements to an indemnity benefit plan.

1.3.1 Health Maintenance Organization (HMO)

The HMO is the most restrictive type of health benefit program. There are normally no out-of-network benefits except for emergencies or if there is no provider in the needed specialty within the network. (In the latter instance, preauthorization from Excellus BlueCross BlueShield is required.)

Members must select a primary care physician (PCP) to coordinate all their care, including referrals to specialists (if required). Many services require preauthorization. This type of plan provides comprehensive benefits, including coverage for routine/preventive care for children and adults. There are normally no deductibles to be met before benefits begin. Member cost-sharing consists of copayments (flat dollar amounts per visit) and/or coinsurance (percentage of Excellus

BlueCross BlueShield's allowed amount). The member has no other financial liability unless he or she has self-referred (if PCP referral is required) or sought services that are not covered. (See the information on patient financial responsibility in the *Administrative Information* section of this manual.)

1.3.2 Point-of-Service (POS)

Members with point-of-service coverage must also select a PCP and get referrals to specialists (if required), but they have the option to seek care on their own without a referral. They can also go out of network for services and still have a level of coverage. Again, member cost-sharing consists of copayments and/or coinsurance. Both of these, however, are higher for out-of-network care. In addition, if they go out of network, they could also be liable for charges beyond the in-network benefit.

1.3.3 Preferred Provider Organization (PPO)

In a PPO health benefit program, the member does not have to select a PCP or get a referral to see a specialist. Some services require preauthorization. While the program covers both in-network and out-of-network services, the member's cost-sharing is higher for out-of-network care. For many services, the member must meet a deductible before coverage begins. Once this occurs, the member is responsible for only copayments and/or coinsurance (depending on the service), unless he or she has gone to an out-of-network provider. In this case, in addition to higher copays/coinsurance, the member could be liable for charges beyond Excellus BlueCross BlueShield's in-network benefit.

1.3.4 Exclusive Provider Organization (EPO)

An EPO health benefit program works much like a PPO. The difference is that there are no out-of-network benefits except for emergencies or if there is no provider in the needed specialty within the network. In the latter case, the member must have preauthorization from Excellus BlueCross BlueShield before the Plan will cover the out-of-network service.

1.3.5 Indemnity

Most indemnity health benefit programs include coverage for both inpatient and outpatient services. Coverage levels may vary depending on the program, or even on the specific health care service. The member must meet a deductible before coverage begins for most services. Members with this type of coverage do not have to select a PCP or get a referral. Some programs may have more limits than others (in other words, some services may not be covered at all). Others may include optional riders that include preauthorization requirements.

There are no restrictions on where members may seek care. However, if they receive care for covered benefits from participating providers, they are responsible only for their contractual cost-sharing amounts. If they receive care from non-participating providers, they could be liable for charges beyond Excellus BlueCross BlueShield's payment to the non-participating provider.

1.3.6 Consumer-Driven or High-Deductible Health Plans (CDHPs/HDHPs)

Consumer-driven or high-deductible health plan products encourage members to act as consumers when spending their benefits dollars, much as they do when making any other purchasing decision. They normally have high deductibles, meaning that the member is financially responsible until reaching an annual upper limit, at which time plan coverage begins. This feature makes the premiums for these programs more affordable for employer groups and individuals.

Health Savings Accounts (HSAs)

One type of consumer-driven health plan incorporates a health savings account. A health savings account, or HSA, is an alternative funding arrangement for traditional health insurance. It is a savings account that offers a different way for consumers to pay for their health care. HSAs enable members to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis.

However, in order to take advantage of an HSA, the member must be covered by a high-deductible health plan (HDHP). The federal government sets the requirements for the HDHP paired with an HSA option. The member is responsible for the deductible and can pay it with funds from the HSA. Members with these accounts may also have a debit card that can be used to purchase health care with funds from the HSA.

Employer groups who purchase a product with an HSA option for their employees cannot require the employee to open an HSA. Therefore, it is important not to make assumptions that the patient has one of these accounts from which to pay his or her deductible and other out-of-pocket expenses (provided there is an adequate amount in the account).

1.3.7 Special Programs for Low-Income Uninsured

Excellus BlueCross BlueShield offers some special programs that provide basic coverage at lower cost to the member. Most have specific eligibility criteria that the prospective member must meet. These programs help fill the gap for people not qualified for government-sponsored programs such as Child Health Plus, Medicaid Managed Care and the Health and Recovery Plan, or HARP. (See the *Government Programs* section of this manual for information about these government-sponsored programs.)

Our special programs follow EPO guidelines. There are no out-of-network benefits, except in the case of emergencies or if there is no provider in the needed specialty within the network. In the latter case, the member must have preauthorization before Excellus BlueCross BlueShield will cover the out-of-network service.

1.3.8. Healthy NY

New York state has a program for low income uninsured persons called Healthy NY. The product information is listed in the Product Portfolio included in this section under New York State Government Programs. There are no out-of-network benefits for Healthy NY products, except for emergency services, unless authorized by Excellus BlueCross BlueShield.

1.3.9 Medicare Supplements

These programs supplement a member's Medicare Part A and Part B coverage. The Centers for Medicare & Medicaid Services (CMS) designs the benefits for Medicare supplements. Excellus BlueCross BlueShield offers several supplements, all of which are indemnity supplements.

1.3.10 Medicare Advantage Programs

A Medicare Advantage program is an alternative to a Medicare supplement. In a Medicare Advantage program, the federal government pays Excellus BlueCross BlueShield a certain amount for each member in the program. Rather than billing Medicare, providers bill Excellus BlueCross BlueShield as primary payer for services rendered to a Medicare Advantage program member. Excellus BlueCross BlueShield, in turn, pays the provider directly according to the negotiated fee schedule.

Medicare Advantage programs follow guidelines of the particular benefit design, such as HMO or PPO. In addition, providers must comply with other requirements specific to these programs. Please see the *Medicare Advantage Programs* section for additional information on these requirements.

1.4 Other BlueCross BlueShield Health Plans

Excellus BlueCross BlueShield is an independent licensee of the BlueCross BlueShield Association and, as such, reciprocates in providing coverage to BlueCross BlueShield members from other areas of the country as well as internationally. Many large corporations have employees in locations other than the location of their corporate headquarters. These employees may be located across the country or the state of New York. Claims for these employees should be submitted through the BlueCard program (described in the *Administrative Information* section of this manual).

Two programs that participating providers across the Excellus BlueCross BlueShield service area should be aware of are the programs for federal employees and New York state employees.

1.4.1 Federal Employee Program

The BlueCross BlueShield Association's Federal Employee Program (FEP) administers the BlueCross BlueShield Service Benefit Plan for federal employees. Members in this program carry an ID card with the Cross and Shield logo. Their member identification number begins with a single letter prefix "R." Providers submit claims to Excellus BlueCross BlueShield and are paid

directly by Excellus BlueCross BlueShield. Providers may call FEP directly using the number on the *Contact List* in this manual.

1.4.2 The Empire Plan for New York State Employees

The Empire Plan is a health benefit program for New York State employees. Part of the program (primarily inpatient) is administered by Empire BlueCross BlueShield and part by another third party administrator. Providers with benefit and eligibility questions on these members may inquire via BlueExchange (see the *Administrative Information* section of this manual) or call the member's home plan (Empire BCBS). Providers should submit claims to Excellus BlueCross BlueShield, except claims that are secondary after Medicare. Medicare forwards these secondary claims directly to Empire BlueCross BlueShield.

1.5 Commitment to Members

1.5.1 Customer Care

Providers may tell members who have any questions or concerns about their coverage to contact Customer Care. (The telephone number for Customer Care is listed on the member's ID card.) Providers may also contact Excellus BlueCross BlueShield with questions and concerns. (See the *Administrative Information* section of this manual for Excellus BlueCross BlueShield requirements for confirming an established relationship with the member.) Excellus BlueCross BlueShield also encourages members to contact Customer Care if they are dissatisfied with any aspect of their care or coverage. If a complaint cannot be resolved immediately on the telephone, a Customer Care Advocate will assist the member, his/her designee, or his/her provider in initiating an appeal or grievance. For information about the grievance and appeals process, see the *Benefits Management* section of this manual.

1.5.2 Privacy and Confidentiality

Excellus BlueCross BlueShield has established procedures for compliance with all federal and state statutes, regulations and accreditation standards governing the use, protection and dissemination of medical records and protected health information, including medical records, claims, benefits, surveys and administrative data. Excellus BlueCross BlueShield utilizes protected health information and data to assist in the delivery of health care, to compensate providers, and to measure and improve care.

Excellus BlueCross BlueShield recognizes that an individual who submits, or authorizes his or her health care provider to submit, medical and dental claims information for processing and payment has an expectation that such information, to the extent it identifies the individual, will not be disclosed in any manner that violates federal or state law or regulation.

Excellus BlueCross BlueShield affords members the opportunity to authorize or deny the release of identifiable protected health information. By law, a member must provide a special

authorization for Excellus BlueCross BlueShield to release protected health information, including mental health, alcohol and substance abuse, abortion, sexually transmitted diseases, genetic testing and HIV/AIDS-related information. Members may authorize the release of some or all of their protected health information by completing an authorization form.

For those members who lack the ability to give authorization, Excellus BlueCross BlueShield will obtain authorization from a legally designated, qualified person, such as the member's legal guardian or person with the member's power of attorney.

Confidentiality of behavioral health and substance use information requires each health care provider to develop policies and procedures to ensure confidentiality of mental health and substance use-related information. Provider policies and procedures must include 1) initial and annual in-service education of staff and contractors, 2) identification of staff allowed to access and the limits of such access, 3) procedures to limit access to trained staff, including contractors, 4) the protocol for secure storage, including electronic storage, and 5) procedures for handling requests for behavioral health and/or substance use information protocols to protect persons with behavioral health and/or substance use disorders from discrimination.

A copy of Excellus BlueCross BlueShield's Privacy Notice is available upon request from Customer Care, as is Excellus BlueCross BlueShield's overall privacy policy.

1.5.3 Member Rights and Responsibilities

Excellus BlueCross BlueShield's members have certain rights and responsibilities, as outlined below. Many of them involve responsibilities, as well as rights, of the practitioners providing service.

A member has the right to:

- Receive all the benefits to which he/she is entitled under his/her contract.
- Receive quality health care through his/her providers in a timely manner and medically appropriate setting.
- Receive considerate, courteous and respectful care.
- Be treated with respect and recognition of his/her dignity and right to privacy.
- Information about services, staff, hours of operation and his/her benefits, including access to routine services as well as after-hours and emergency services and members' rights and responsibilities.
- Participate in decision-making with his/her physician about his/her health care.
- Get a second opinion.
- Obtain complete, current information concerning a diagnosis, treatment and prognosis from a provider in terms that he/she can reasonably be expected to understand. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member's behalf.

- Refuse treatment as allowed by law, and be informed by his/her physician of the medical consequences.
- Refuse to participate in research.
- Confidentiality of medical records and information, with the authority to approve or refuse Excellus BlueCross BlueShield's disclosure of such information, to the extent protected by law.
- Receive all information needed to give informed consent for any procedure or treatment.
- Access to his/her medical records as permitted by New York state law.
- Express concerns and complaints about the care and services provided by physicians and other providers, and have Excellus BlueCross BlueShield investigate and respond to these concerns and complaints.
- Candid discussion of appropriate or medically necessary treatment options for his/her condition, regardless of cost or benefit coverage.
- Care and treatment without regard to age, race, color, sex or sexual orientation, religion, marital status, national origin, economic status or source of payment.
- Voice complaints or appeals and recommend changes in benefits and services to staff, administration and/or the New York State Department of Financial Services or Department of Health, without fear of reprisal.
- Formulate advance care directives regarding his/her care. To obtain a Health Care Proxy form, contact Excellus BlueCross BlueShield.
- Contact one of Excellus BlueCross BlueShield’s service departments to obtain the names, qualifications and titles of providers who are responsible for his/her care.
- All information about Excellus BlueCross BlueShield, its services and his/her providers and procedures.
- Make recommendations regarding Excellus BlueCross BlueShield’s members’ rights and responsibilities.

A member has the responsibility to:

- Be an active partner in the effort to promote and restore health by:
  - openly sharing information about his/her symptoms and health history with his/her physician;
  - listening;
  - asking questions;
  - becoming informed about his/her diagnosis, recommended treatment and anticipated or possible outcomes;
  - following the plans of care he/she has agreed to (e.g., taking medicine, making and keeping appointments);
  - returning for further care, if any problem fails to improve; and

- accepting responsibility for the outcomes of his/her decisions.

- Participate in understanding his/her health problems and developing mutually agreed-upon treatment goals.
- Have all care provided, arranged or authorized by his/her primary care physician (PCP), where applicable.
- Inform his/her PCP if there are changes in his/her health status, where applicable.
- Obtain services authorized by his/her PCP, where applicable.
- Share with his/her PCP any concerns about the medical care or services that he/she receives, where applicable.
- Permit Excellus BlueCross BlueShield to review his/her medical records in order to comply with federal, state and local government regulations regarding quality assurance and to verify the nature of services provided.
- Respect time set aside for his/her appointments with providers; give as much notice as possible when an appointment must be rescheduled or cancelled.
- Understand that emergencies arise for his/her providers and that his/her appointments may be unavoidably delayed as a result.
- Respect staff and providers.
- Follow the instructions and guidelines given by his/her providers.
- Show his/her ID card and pay his/her visit fees to the provider at the time the service is rendered.
- Become informed about Excellus BlueCross BlueShield's policies and procedures, as well as the office policies and procedures of his/her providers, so that he/she can make the best use of the services that are available under his/her contract.
- Abide by the conditions set forth in his/her contract.

1.5.4 Member Surveys

Excellus BlueCross BlueShield conducts member satisfaction surveys at least annually. The surveys assess member satisfaction with the care and services members receive. The surveys are used to identify opportunities for improvement. They may also be used to measure the success of any actions that are taken to improve the care and services members receive.

1.6 Product Overviews

The chart on the following pages represents a brief overview of each type of health benefit program described previously in this section.

Product Portfolio
Excellus BlueCross BlueShield

Product Type	***Product referred to as:***
HMO (Health Maintenance Organization) ▪ Managed care product. ▪ Primary care provider (PCP), referrals and preauthorizations may be required (see *Benefits Management* section of this manual). ▪ Must use participating (in-network) providers. ▪ Provides comprehensive benefits, including coverage for routine/preventive care for children and adults. ▪ First dollar coverage through copayments and/or coinsurance (no deductibles). ▪ Multiple copayment options available.	Blue Choice 30 Copay Option (Rochester) Blue Choice 25 Copay Option (Rochester) HMOBlue 25 (CNY, So. Tier & Utica) HMOBlue 30 (CNY, So. Tier & Utica) Excellus BCBS HMO
POS (Point-of-Service) ▪ Provides in and out-of-network coverage. ▪ PCP and preauthorization may be required for highest level of coverage (similar to HMO). ▪ Member decides at "point of service" whether to coordinate care through PCP. If the member chooses not to coordinate care, there is increased cost-sharing for out-of-network coverage. ▪ First dollar in-network coverage through copayments and/or coinsurance (no deductibles).	BluePoint 2 BluePoint 3

Product Type	***Product referred to as:***
PPO (Preferred Provider Organization) ▪ No PCP required. ▪ Some services require precertification or preauthorization.* ▪ In-network and out-of-network coverage. o In-network – participating providers must be used. o Out-of-network –non-participating providers may be used, but higher cost-sharing may apply. ▪ Typically, deductible must be met, then copayment/coinsurance. ▪ Multiple copayment, coinsurance and deductible options available, providing a range of benefit levels from which to choose. ***Preauthorization requirements mirror those of HMO products**	Excellus BluePPO BlueCard PPO (Rochester) BluePreferred PPO (CNY, So. Tier & Utica) College Blue Student Essentials HealthyBlue* -Copay Plan -Copay & Deductible Plan SimplyBlue* -Copay Plan -Copay & Deductible Plan Platinum Standard IND PPO (only available to members who had Direct Pay Point of Service) Simply Blue Plus
EPO (Exclusive Provider Organization) for Employer Groups ▪ No PCP required. ▪ Some services require precertification or preauthorization. ▪ In-network coverage only, and in-network providers must be used. ▪ Out-of-network services not covered. ▪ Typically, deductible must be met, then copayment/coinsurance. ▪ Multiple copayment/coinsurance and deductible options available, providing a range of benefit levels from which to choose.	Excellus Blue EPO Additional customized plans exist (unions, etc.)

Product Type	***Product referred to as:***
EPO (Exclusive Provider Organization) for Direct Pay Members ▪ No PCP required. ▪ Some services require preauthorization or precertification*. ▪ In-network coverage only, and in-network providers must be used. ▪ Out-of-network services not covered. ▪ Typically, deductible must be met, then copayment/coinsurance. ▪ Multiple copayment, coinsurance and deductible options available, providing a range of benefit levels from which to choose. ▪ Premium assistance may be available for those who qualify. Must apply through www.healthbenefitexchange.ny.gov. ***Preauthorization/precertification requirements for Direct Pay Metal Plans mirror those of our HMO products.** **+Lower cost share options available to those who qualify.**	Platinum Standard Platinum Select Gold Standard Gold Select Silver Standard+ Silver Select+ Bronze Standard Bronze Select Base Bassett Gold Select (Delaware, Herkimer and Otsego counties only)
Indemnity ▪ No PCP required. ▪ Some groups may require preauthorizations. ▪ Deductible must be met first, and then coinsurance applies. ▪ Comprehensive (hospital, physician, ancillary) coverage. ▪ Typically includes an out-of-pocket maximum. ▪ Prescription coverage (if included) is generally the same as the medical – deductible, then coinsurance or copayment. ▪ Participating providers accept our payment plus member cost-sharing as payment in full. ▪ Some services not covered if rendered by non-participating provider.	Classic Blue Traditional Classic Blue Secure (over 65 retiree plan) College Blue Comprehensive Medicare Supplements (see separate section) Additional customized plans exist (unions, etc.).

Product Type	***Product referred to as:***
High-Deductible Health Plan (HDHP) – Health Savings Account Qualified Plans (HSA) Deductible must be met before most services are covered. Lower premiums. More member responsibility. ***Preauthorization requirements for HealthyBlue, SimplyBlue and SimplyBlue Plus mirror those of our HMO products.** ****Native American plans and Silver cost-share reduction plans do not qualify for a health savings account.**	HealthyBlue HDHP* SimplyBlue HDHP* SimplyBlue Plus HDHP* Silver Select** Bronze Standard** Bronze Select**
Medicare Supplements Pays after Medicare. Government-structured benefit package.	Medicare Supplemental
Medicare Advantage Providers submit claims directly to Excellus BCBS. Excellus BCBS pays as primary. Includes all Medicare benefits, plus preventive care and other value-added benefits. Highest level of benefit for services from participating providers. PCP and referrals required for HMO and HMO-POS products. Precertification requirements. To qualify, members must have Medicare Parts A and B, and not be in treatment for end-stage renal disease (ESRD).	Medicare Blue Choice HMO (Rochester) Medicare Blue PPO Medicare Bassett HMO-POS
New York State Government Programs New York State programs administered by Excellus BCBS in approved counties. Comprehensive (hospital, physician, ancillary) coverage. Specific eligibility and income requirements. PCP required. Referrals and/or preauthorizations may be required. ***Enrollment Assistants or Community IPA/Navigators are available to help prospective members with eligibility and enrollment.**	Healthy NY EPO Child Health Plus* HMOBlue Option* (CNY, Southern Tier and Utica) Blue Choice Option* Rochester Region Blue Option Plus (HARP product) Premier Option Plus (HARP product) HARP=Health and Recovery Plan

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2.0 Administrative Information

2.1 Contacting Excellus BlueCross BlueShield F

Excellus BlueCross BlueShield employs individuals trained to perform specific services and support specific provider needs. The following *Contact List* includes telephone numbers, fax numbers, addresses, Web page addresses and email addresses of the Excellus BlueCross BlueShield departments and other agencies with which providers most often interact.

Contact List

Name	Comments	Telephone No.	Fax No.
Excellus BlueCross BlueShield online	ExcellusBCBS.com/Provider This website allows you to check member eligibility, verify benefits, check claim status and request preauthorization. Also, you can learn about member health benefit program requirements, along with many other options that are available when you register for online access. ▪ Registration can be completed online. ▪ Review a member's eligibility for benefits. ▪ Check claim status. ▪ Update practice information. ▪ Request a claim adjustment. ▪ Enter referrals. ▪ Request a preauthorization. ▪ View fee schedule information. ▪ Review clinical editing. ▪ View pharmacy information. ▪ View medical and administrative policies. ▪ Compare hospital quality information.		
Customer Care All Excellus BlueCross BlueShield Regions	Questions about claims, member benefits and eligibility, etc. Customer Care is available Monday through Thursday, 8 a.m. to 5:30 p.m., Friday 9 a.m. to 5:30 p.m.	1-800-920-8889	

Name	Comments	Telephone No.	Fax No.
Customer Care, Child Health Plus, Medicaid Managed Care (including HARP)	▪ Child Health Plus ▪ Blue Choice Option/HMOBlue Option ▪ Premier Option ▪ Blue Option Plus/Premier Option Plus	1-800-920-8889	1-866-433-8250
Customer Care, Direct Vision Line	Questions about vision claims, member benefits and eligibility, etc.	1-855-272-6961	
Accredo Pharmacy, specialty pharmacy for patient-administered and provider-administered medications	Patient-administered Provider-administered	1-866-413-4137 1-866-297-0930	1-888-773-7386 1-888-773-7386
1099 Support Unit	Questions regarding W-9 forms or 1099 information	1-877-660-9060	
Behavioral Health Preauthorizations	Mental health/psychiatric hospitalization, inpatient chemical dependency, outpatient mental health (select products only), psychological evaluation	Commercial Lines of Business 1-800-363-4658 Safety Net Lines of Business (HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus, Blue Option Plus and Premier Option Plus) 1-844-694-6411	
BlueCard®	Information on members from out-of-area BlueCross BlueShield health plans Inquiries regarding claim status	1-800-676-2583 1-800-404-1445 (from your telephone key pad, select "2" for claims)	
BlueExchange (Web-based)	Registration required for use. Providers may register directly from the website.		
CAQH (Council for Affordable Quality Healthcare)	For practitioner credentialing www.caqh.org/ucd.php	1-888-599-1771	

Name	Comments	Telephone No.	Fax No.
Case Management (Commercial Products) **Member Care Management** **Chronic Care Management**	To make referrals	1-800-434-9110	1-877-243-6819
Case and Disease Management, Government Programs	To refer members of Child Health Plus, HMOBlue Option, Blue Choice Option, Premier Option, Blue Option Plus/Premier Option Plus for case management	1-844-520-9830 (Disease Management) 1-844-694-6411 (Case Management)	
Care Management, Behavioral Health (Commercial Products)	To make a referral, call Monday through Thursday, from 8 a.m. to 5 p.m., and Friday from 9 a.m. to 5 p.m. If you call after-hours, leave a message on the confidential voice mail and your call will be returned the next business day.	1-800-277-2198	
Claim Status	Call Customer Care or use the website (registration required)		
Claims Submission, Electronic	See eCommerce below		
Claims Submission, Paper	Excellus BlueCross BlueShield PO Box 22999 Rochester, NY 14692		
CompassionNet	Case management for children with life-threatening illnesses	CNY 1-315-477-9596 CNYST 1-607-795-8863 Rochester 1-585-214-1333 Utica 1-877-515-8490	
Computer Sciences Corporation (CSC) (ePaces Medicaid eligibility inquiries)	▪ Institutional (Clinics, hospitals, etc.) ▪ Practitioner (MDs, Dentists) ▪ Professional (DME, non-MDs)	1-800-522-1892 1-800-522-5518 1-800-522-5535	
Coordination of Benefits (COB)	See Other Party Liability (OPL)		

Name	Comments	Telephone No.	Fax No.
Credentialing, Central New York, CNY So. Tier and Utica Regions (credentialing questions only)	▪ New applicants ▪ Recredentialing	1-315-798-4362 1-315-792-9705	1-315-731-9626
Credentialing, Rochester Region (credentialing questions only)	▪ New applicants ▪ Reappointments (A-K) ▪ Reappointments (L-Z)	1-585-399-6632 1-585-238-3629 1-585-453-6412	1-585-399-6610
Credit and Collection (address to return overpayments)	Excellus BlueCross BlueShield Credit and Collection 333 Butternut Drive Syracuse, NY 13214-1803		
Departmental Appeals Board (HHS) (Medicare Advantage only)	Department of Health & Human Services Departmental Appeals Board, MS 6127 Medicare Appeals Council Cohen Building, Room G-644 330 Independence Avenue, SW Washington, DC 20201		
Disease Management Member Care Management Complex Care Management (Commercial products)	To refer a member for case management	1-800-434-9110	1-877-243-6819
eCommerce	Electronic transactions including claim submittal and electronic remits	1-877-843-8520	
ePaces (software for Medicaid eligibility inquiries)	www.emedny.org	Call Computer Sciences Corp.	

Name	Comments	Telephone No.	Fax No.
Fair Hearing (Medicaid managed care and HARP)	New York State Office of Temporary and Disability Assistance Office of Administrative Hearing Unit Managed Care Hearing Unit PO Box 22023 Albany, NY 12201-2013 http://otda.ny.gov/hearings/	1-800-342-3334	1-518-473-6735
Federal Employee Program (FEP)	Member ID number prefix is the letter "R"	1-800-584-6617	CNY and CNYST 1-315-792-9738 Rochester 1-585-399-6617 Utica 1-315-792-9738
24-Hour Nurse Advice Line	Free program (available 24/7) for members in selected plans to call for information about chronic conditions and other health-related information.	Commercial Lines of Business 1-800-348-9786 TTY 1-877-471-7033 Safety Net Lines of Business (HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus, Blue Option Plus and Premier Option Plus): 1-844-611-4628	
Health Home Triage (Medicaid managed care/HARP)	For information related to the Health Home Program	1-844-324-7861	
Help Desk	Resetting log in and passwords	1-866-238-4216	
HIV Counseling & Testing	NYSDOH Program	1-800-541-AIDS	
InfoCheck (Rochester Region only) Phone line available 24/7 except 5-6 a.m., M-Fri and Sunday midnight until 6 a.m. Monday	May be used to check eligibility, benefits, referrals and claim status for managed care. Requires Provider NPI.	1-585-454-7200 1-800-452-1487	

Name	Comments	Telephone No.	Fax No.
Livanta	Medicare Appeals	1-866-815-5440 TTY: 1-866-868-2289	1-855-236-2423
Medical Intake	Most referrals and prior authorizations.	Commercial Lines of Business 1-800-363-4658 Safety Net Lines of Business (HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus, Blue Option Plus and Premier Option Plus) 1-844-694-6411	Commercial Lines of Business 1-877-203-9401 Safety Net Lines of Business (HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus, Blue Option Plus and Premier Option Plus) 1-844-279-7140
Medical Policy Coordinator	Questions and comments on medical policies.	Call Customer Care	
Medical Specialty Medication Review Program	To request preauthorization forms and specialty pharmacy information.	Commercial Lines of Business 1-800-306-0151 Safety Net Lines of Business (HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus, Blue Option Plus and Premier Option Plus) 1-844-694-6411	Commercial Lines of Business 1-800-306-0188 Safety Net Lines of Business (HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus, Blue Option Plus and Premier Option Plus) 1-855-346-4418
Medicare Advantage Coding Review	Excellus BCBS Revenue Integrity Department 165 Court St. Rochester, NY 14647	1-585-238-4384	1-585-327-6577

Name	Comments	Telephone No.	Fax No.
Member Eligibility	Call Customer Care, or use the website (registration required)		
Member Grievances	During regular business hours, call or visit Customer Care for the applicable program.	Phone: 1-800-205-9082 Available to Medicaid managed care members only.	
National Provider Identifier (NPI) Enumerator	Email: customerservice@npienumerator.com	1-800-465-3203 TTY 1-800-692-2326	NPI Enumerator PO Box 6059 Fargo, ND 58108-6059
Neonatal Intensive Care Unit (NICU)	Inpatient preauthorizations for admission to NICU, case management, initiation of concurrent review process, monitoring of medical necessity and appropriate level of care.	Commercial Lines of Business Request authorization via our Medical Intake Unit at 1-800-363-4658 Safety Net Lines of Business (HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus, Blue Option Plus and Premier Option Plus) 1-844-694-6411	Safety Net Lines of Business (HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus, Blue Option Plus and Premier Option Plus) 1-844-279-7140
Other Party Liability (OPL) Coordination of Benefits for Worker's Comp, No Fault and to discuss primacy and review COB claims	Central New York, CNY So. Tier and Utica Regions Traditional Indemnity Managed Care/PPO Rochester Region Call Customer Care	1-800-448-8290 1-877-731-0226	
PCP Selection Form	Fax form for CHP, Medicaid managed care, Blue Option Plus and Premier Option Plus members to select or change primary care physician		1-844-299-1581
Pharmacy Help Desk	Questions, exceptions, prior authorizations	1-800-724-5033	Fax prior authorization forms 1-800-956-2397

Name	Comments	Telephone No.	Fax No.
Preauthorization	Most services that require preauthorization; inpatient or outpatient. Request via Clear Coverage™ Web tool online at: ExcellusBCBS.com/Provider	Commercial Lines of Business 1-800-363-4658 After-hours line (for all regions): 1-877-303-8887 Safety Net Lines of Business (HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus, Blue Option Plus and Premier Option Plus) 1-844-694-6411	Commercial Lines of Business Inpatient (for all regions): 1-800-292-5109 Outpatient (for all regions): 1-800-222-8182 Safety Net Lines of Business (HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus, Blue Option Plus and Premier Option Plus) 1-844-279-7140 Concurrent Review Documentation Safety Net Lines of Business 1-855-742-0126
Preauthorization, Imaging Studies (CT, MRI, MRA, PET, nuclear cardiology)	eviCore healthcare Requests may be made via Web, fax or phone. Special form required for faxed requests. Web access from the Excellus BlueCross BlueShield website: ExcellusBCBS.com/Provider	1-866-889-8056 Monday through Friday from 7 a.m. to 7 p.m.	1-866-466-6964

Name	Comments	Telephone No.	Fax No.
Privacy Questions and Complaints	For information about our privacy practices or concerns: For privacy rights or questions: Privacy complaints: Call, mail or email Mailing address: Privacy Officer 333 Butternut Drive Dewitt, NY 13214-2313 Email: privacy.officer@excellus.com	Call Customer Care or Provider Relations 1-866-584-2313	
Provider Advocate Unit	PO Box 4717 Syracuse, NY 13221	1-800-920-8889	315-671-6656
Provider File Maintenance	To update provider information, use our online form or fax/mail form. In addition, you can send us changes by mail or fax using your company letterhead. ExcellusBCBS.com/ProviderUpdateInfo		CNY, CNYST and Utica 1-800-676-6285 Rochester 585-262-2017
Provider Relations	See list of Provider Relations representatives on the website, ExcellusBCBS.com/ProviderContactUs, or contact Customer Care.		
Quit For Life	Smoking cessation program for eligible members.	1-800-442-8904	

Name	Comments	Telephone No.	Fax No.
Referrals (May also use Web to request referrals)	Representatives available: Monday through Thursday from 8 a.m. to 5 p.m. Friday from 9 a.m. to 5 p.m.	1-800-363-4658	Inpatient (for all regions): 1-800-292-5109 Outpatient (for all regions): 1-800-222-8182
Specialty Pharmacy	*See Accredo and Walgreens*		
Sterilization and Hysterectomy Consent Forms (Medicaid managed care)	To request patient consent forms for sterilization or hysterectomy. Via Web: www.health.ny.gov/health_care/medicaid/publications/ldssforms.htm	1-518-473-4852	1-518-486-1432
Taxonomy (to select appropriate taxonomy)	To view a complete list of taxonomy codes, go to the following website: wpc-edi.com/reference/		
Vaccines for Children Program Medicaid managed care (HMOBlue Option & BlueChoice Option) and Child Health Plus only	www.health.ny.gov/prevention/immunization/vaccines_for_children.htm	1-800-543-7468	518-473-4222
Walgreens Specialty Pharmacy, for patient-administered and provider-administered medications	Patient-administered Provider-administered	1-866-435-2170 1-866-435-2171	1-866-435-2172 1-866-435-2173
Web Security Help Desk	Monday through Thursday: 8 a.m. to 4:30 p.m. Friday: 9 a.m. to 4:30 p.m.	1-800-278-1247	

(end)

2.2 Obtaining Member Information from Excellus BlueCross BlueShield

The privacy rights of members are very important to Excellus BlueCross BlueShield, as is its relationship with participating physicians and other health care providers. Excellus BlueCross BlueShield has procedures in place to ensure that only properly authorized parties have appropriate access to members' protected information. In addition, Excellus BlueCross BlueShield has implemented a process that places extra emphasis on protecting confidential patient information.

> **Note:** For more information about Excellus BlueCross BlueShield policies regarding privacy and confidentiality, see the *Introduction* section of this manual.

When a physician or other health care provider calls Excellus BlueCross BlueShield requesting information about a member, the provider will be required to answer a few questions before the Excellus BlueCross BlueShield will release the information.

- First, the participating provider must confirm his/her identity by supplying a provider identification number.
- Next, the provider must confirm his/her relationship with the member by supplying the member's full name and ID number. If the provider is unable to provide the member ID number, the provider must supply at least one of the following, in addition to the member's name:
  - Patient birth date
  - A claim number or authorization number
  - Patient address
  - Name of primary physician (when applicable)

  > **Note:** If the member is an Excellus BlueCross BlueShield employee (or dependent of an Excellus BlueCross BlueShield employee), the provider must supply the subscriber ID.

If neither the provider's identity nor the provider/patient relationship can be confirmed, Excellus BlueCross BlueShield will not release patient information.

2.3 Excellus BlueCross BlueShield Connectivity F

2.3.1 Website

The Excellus BlueCross BlueShield website, ExcellusBCBS.com, carries up-to-date information for members and providers. See the chart titled *Contents of the Excellus BlueCross BlueShield website* at the end of this section of the manual for a broad overview.

The material presented on the provider pages of the website is also available by calling Customer Care (see *Contact List*).

> **Note:** In case of a discrepancy between any materials presented on the website and the up-to-date version of that material on file at Excellus BlueCross BlueShield, the latter version controls.

Menu Options on the Provider Home Page

Some of the menu options, such as those listed below, are available on the provider page of the Excellus BlueCross BlueShield website and are discussed in sections of this *Participating Provider Manual*.

- Coverage & Claims
- Referrals & Auths
- Coding & Billing
- Prescriptions
- Patient Care
- Education

2.3.2 Online Services

Participating providers with computers in their offices may obtain member and claim information as well as perform certain transactions via the Excellus BlueCross BlueShield website. Providers must **register** to access information via the website.

Providers who have registered have access to:

- Check member eligibility and benefits
- Check claims or request an adjustment
- Manage preauthorization requests

There are other transactions possible from the website, including billing resources such as electronic remittance. (See the *Billing and Remittance* section of this manual for information regarding electronic remittance and payment.)

To Register for Web Access

For Web access, providers may register directly from the Excellus BlueCross BlueShield website.

> **Note:** Facilities must complete an application that can be obtained from Customer Care (see *Contact List*).

- Go online to ExcellusBCBS.com/Provider.
- Go to *Register Now!* and select the role that applies from the "I am a . . ." drop-down menu.
- Click *GO*.
- This will bring you to your specific registration page.
- Hospital accounts department, emergency department and urgent care facilities will be directed to complete a Web registration form and submit it online.
- Participating practitioners must establish a Master Account. This account provides access to our online tools and allows for the management of staff access.
- You will be asked for your Excellus BlueCross BlueShield provider ID number. This is your P010 number.
- Once you enter your practitioner information on the *Provider Registration* pages, click *Submit*.
- *eCommerce* will establish the Master Account for those required to fax, and notify you when the account is ready. Allow up to five days.
- Once the Master Account is established, log in with your username and password.

- Click on the "Go" button in the *Add, Update or Delete Web Accounts for Your Staff* box. This feature allows you to give staff members access to our online tools. To ensure that only authorized staff have access, staff account must be managed by the practitioner or office manager. You may create office staff accounts or delegate the task to the office manager.
- To delegate management of staff accounts, select *Add Office Manager Account* to create this account prior to adding staff accounts. You will be prompted to create a temporary password. Once this account is created, you or the office manager can add staff accounts or use the *Delete Account* option to remove access for employees who leave your organization.

2.3.3 Electronic Billing

Excellus BlueCross BlueShield is compliant with guidelines from the Centers for Medicare & Medicaid Services (CMS) regarding the HIPAA EDI Transaction and Code Set regulation and is prepared to receive HIPAA-compliant transactions. Contact *eCommerce* for more information about electronic billing.

2.3.4 Hospital Comparison Tool

Excellus BlueCross BlueShield makes available through its website a hospital comparison tool. It is an online tool that compares the performance of selected hospitals on more than 175 procedures and medical conditions. Excellus BlueCross BlueShield offers access to the hospital comparison tool as a benefit to its members and providers.

The tool allows the user to obtain an independent comparison of hospitals within a specific geographic area by procedure or diagnosis. Users may create a personalized report that compares hospital performance based on information hospitals provide to CMS, state health departments or local agencies. Use of the hospital comparison tool is completely anonymous.

The generated reports provide an analysis of patients hospitalized for certain conditions, including the number of patients treated at each hospital (patients/year), the percentage of patients who developed problems (complications), the percentage of patients who died (mortality), the average number of days people stayed in each hospital (length-of-stay), and the average price the hospital charged.

2.4 Determining Member Eligibility for Benefits F

Before providing services, it is important to determine financial responsibility by verifying whether the patient has coverage for the service or should be treated as private pay. Participating providers may check member eligibility through the website or by calling Excellus BlueCross BlueShield. Providers must be registered in order to have access through the Web. For registration information, see the paragraphs above under *Online Services*.

Member cards also contain valuable information, but it is still important to verify benefits before providing services.

2.4.1 Member Cards

Each subscriber is assigned an identification (ID) number, and each member is eligible to receive his or her own member card. Each of Excellus BlueCross BlueShield's health benefit programs has its own unique card.

What to Look for on the Member Card

Member cards carry vital information to assist providers in doing business with Excellus BlueCross BlueShield. Provider offices should copy the front and back of the cards, as both sides contain important information, including information providers need to submit claims and coordinate patient care. While cards differ from product to product, there are some standard elements:

- Logo – The BlueCross BlueShield logo is on all BlueCross BlueShield plan identification cards.
- Suitcase logo – Most BlueCross BlueShield member cards include a logo that looks like an outline of a suitcase. This logo is an indication that providers should submit claims for a member from another BlueCross BlueShield health plan to the BlueCross BlueShield plan with which the provider participates. For example, if a provider participates with Excellus BlueCross BlueShield and provides services to a member from BlueCross BlueShield of Alabama, the claim should be submitted to Excellus BlueCross BlueShield.
- Rx logo – The Rx logo indicates that the member either has prescription drug coverage through Excellus BlueCross BlueShield's pharmacy benefit manager (see the *Pharmacy* section of this manual) or is eligible for the Rx Value-Add Prescription Drug Discount Program.
- HealthPlex Inc. logo – The HealthPlex logo indicates that the member has dental coverage for Medicaid managed care and Child Health Plus members.
- Product Name – The name of the health benefit program (except for Child Health Plus, which carries a "group" identifier of "C").
- Subscriber Name – This is the name of the person holding the policy. If the patient is a dependent, the patient's name may not be on the card.
- Identification Number – The identification number is that of the subscriber. It is required on all claims. Most BlueCross BlueShield identification numbers include a three-letter prefix that must be included. Federal Employee Program member cards have a one-letter prefix (R). Member cards for Medicaid managed care members also include the member's Medicaid client identification number (CIN).
- Medicaid managed Care restricted recipients will have "RRP" listed after the last name on their member identification card. See the Government Programs section of this manual for more information.
- Copay amount(s).
- Telephone numbers.
- Address for paper claim submittal.

2.4.2 Member Eligibility Telephone Inquiry

Before placing a call to Excellus BlueCross BlueShield, please have all required information, such as the patient's full name, subscriber ID and your NPI. Follow the prompts to select the correct options for your inquiry. Knowing the patient's type of coverage (indemnity, PPO, HMO, etc.) will help you choose the right options. Choosing the right options can decrease the time it takes to get the information you need. Limited benefit eligibility information is available via Excellus BlueCross BlueShield's interactive voice response telephone system. However, if you have selected the correct options and need to be transferred to a representative, you will more likely be transferred to a representative trained in the appropriate product line or service area.

Because our subscriber ID numbers include an alpha character, you will be asked to speak the subscriber ID rather than key it in via the telephone keypad. Speak slowly and clearly and say "zero" rather than "oh" for the numeral. Do not include the three-character prefix.

Use the BlueCard eligibility telephone line or BlueExchange (online) rather than IVR to check eligibility for out-of-area BlueCross BlueShield members. Call the appropriate FEP (federal employee program) service line to check eligibility for federal employees. Contact information for BlueCard and FEP is on the *Contact List*.

Rochester Region providers also have access to *InfoCheck*. See below for instructions for using *InfoCheck*.

2.4.3 InfoCheck

Note: This option available to Rochester region providers only.

InfoCheck is a telephone inquiry system that providers can use for limited eligibility and benefit information, primarily about Blue Choice members. It is available 24 hours a day, seven days a week with two small exceptions: from 5 a.m. to 6 a.m., Monday through Friday and from Sunday at midnight until 6 a.m. Monday. See the *Contact List* for telephone numbers.

Anyone calling in will hear the following message: *This line is for providers only. If you are a member, press 1. Otherwise, remain on the line.*

After a brief pause to allow members to press 1, various options (described in the table on the following page) are available to the provider.

InfoCheck Options (Rochester Region Providers Only)		
Menu Option	**To access option**	**Information available**
Optical Benefits (Requires NPI, subscriber ID and member date of birth)	Press 1	• Date of last eye exam • Routine eye exam benefit • Date of last eyewear purchase • Routine eyewear benefit • Cataract surgery eyewear benefit

InfoCheck Options (Rochester Region Providers Only)		
Menu Option	**To access option**	**Information available**
Membership & Benefits (Requires NPI, subscriber ID and member date of birth)	Press 2	**Non-Blue Choice contracts** • Contract type • Suffix number **Blue Choice contracts** • Contract type • Name, suffix and effective date of individual on contract • PCP/Alt PCP name and office visit copay • Specialist office visit copay • Mental health office visit limits and copay • Chiropractor office visit copay
Blue Choice Referrals (Requires NPI, subscriber ID, member date of birth and Excellus BCBS PIN. Option 3 requires referral No. Not a method to generate a referral.)	Press 3	Verify existing referral information only. Cannot generate referral via InfoCheck.
Blue Choice Claims Status (Requires NPI, subscriber ID, member date of birth and Excellus BCBS PIN. Info available only for Blue Choice claims.)	Press 4	• Claim number, procedure code, diagnosis code • Date paid or denied and, if paid, the amount by procedure code
Transfer to Blue Choice	Press 5	During business hours, this transfers the caller to a Blue Choice representative.
Transfer to Blue Shield	Press 6	During business hours, this transfers the caller to a Blue Shield representative.
End call	Press 9	Ends the call.

2.5 Excellus BlueCross BlueShield Publications

2.5.1 Participating Provider Manual

Excellus BlueCross BlueShield's *Participating Provider Manual* is intended as a reference and source document for physicians and other providers who participate with Excellus BlueCross BlueShield. The manual is intended to clarify various provisions of a provider's participation agreement.

2.5.2 Provider Newsletter and eAlerts

Excellus BlueCross BlueShield's provider newsletter, *Connection*, is an electronic publication that is issued and posted to the website on a monthly basis. The newsletter is designed to keep participating providers and their office staff apprised of developments in Excellus BlueCross BlueShield policies and products.

Each month, an eAlert that links to the newsletter is emailed to providers who have opted in to receive the publication electronically. To opt-in, providers must go to ExcellusBCBS.com/ProviderNewsUpdates *> Receive Our Monthly Newsletter and Provider Communications by Email*. The newsletter email notification will only be sent to those who have completed the opt-in process.

Periodically, we also issue bulletins via email "eAlerts." Once you have opted in to receive the *Connection* newsletter electronically, you will also receive general informational bulletins electronically.

If the provider's office does not have access to the Internet, they can receive paper copy of the newsletter or bulletins via traditional mail. To request a paper copy, please contact Customer Care.

2.5.3 Ad Hoc Communications

As needed, Excellus BlueCross BlueShield sends written notifications to participating providers regarding new and revised policies and procedures and other information of value. Excellus BlueCross BlueShield issues bulletins, letters and other notices in instances when notification is required outside the normal newsletter schedule, or when the information affects only a small, specific audience of providers.

2.6 Provider Office Environment

2.6.1 Office Site Review

Excellus BlueCross BlueShield may conduct site reviews of the office locations of physicians and other health care providers at initial credentialing, when a provider opens a new location or when there are member complaints.

An office site review includes assessments of patient safety and privacy, office operations and confidentiality, appointment availability and accessibility, security of pharmaceuticals and prescription pads, and office record maintenance. The *Credentialing Site Visit Checklist* (Available via the provider section of the website at ExcellusBCBS.com/ProviderEnrollmentForm. The form lists the criteria Excellus BlueCross BlueShield reviewers use during a site review.

Excellus BlueCross BlueShield will conduct a site visit upon receiving formal or informal complaints from two or more members within 12 months. A complaint may, but not always, pertain to physical appearance, handicap access, waiting room or exam room space. Elements from the *Credentialing Site Visit Checklist* will be utilized for the visit. The areas to be reviewed include *but are not limited to* the following requirements on the checklist: Facility and Environment, Office

Operations, Pharmaceuticals and Office Record Maintenance. All applicable site visit standards must be met.

Wheelchair Accessibility

As part of the Office Site Review, reviewers gather information to better serve members with disabilities. This information does not affect a provider's credentialing status. Accessibility information is included in Excellus BlueCross BlueShield provider directories.

2.6.2 HIPAA Compliance

> **Note:** This section gives a general overview of HIPAA requirements. For information about Excellus BlueCross BlueShield compliance with HIPAA standards on privacy and confidentiality, see the *Introduction* section of this manual. For information regarding HIPAA-compliant availability of eligibility, claims, and referral information, see paragraphs about Member Eligibility, Remote Access Inquiry, Online Inquiry Systems, as well as referral and preauthorization information in the *Benefits Management* section of this manual. For information about compliance with HIPAA standards on electronic submission of claims, see the *Billing and Remittance* section of this manual.

The Health Insurance Portability and Accountability Act of 1996, as amended (commonly known as HIPAA), was designed to improve the efficiency and effectiveness of the health care system. It includes administration simplification provisions that require the U.S. Department of Health and Human Services to adopt national standards for electronic health care transactions. Recognizing that advances in electronic technology could erode the privacy of health information, Congress incorporated into HIPAA, provisions that mandate the adoption of federal privacy protections for individually identifiable health information. This information is referred to as Protected Health Information, or PHI.

The HIPAA Privacy Rule provides standards for the protection of PHI in today's world where information is broadly held and transmitted electronically. HIPAA's privacy rule requires that health care providers and other specified entities ("covered entities") take certain actions to maintain confidentiality. Some of these actions are:

- Notifying patients about their privacy rights and how their PHI can be used
- Adopting and implementing privacy procedures
- Training employees to understand privacy procedures
- Designating a Privacy Officer responsible for seeing that privacy procedures are adopted and followed
- Securing patient records containing PHI so they are accessible only to specified authorized individuals

Who Must Comply

The following individuals and organizations must comply with the HIPAA standards. They are referred to as "covered entities."

- Health care providers who electronically conduct the financial and administrative transactions listed under *Applicable Transactions*, below

- Health plans such as Excellus BlueCross BlueShield and Medicare and Medicaid, employer plans under the Employee Retirement Income Security Act (ERISA), Indian Health plans, and self-administered plans (except those with fewer than 50 participants)
- Health care clearinghouses

Applicable Transactions

All covered entities that conduct any of the following standard transactions are required to use HIPAA-compliant electronic language and codes:

- Health care claims or equivalent encounter information
- Health care payment and remittance advice
- Coordination of benefits
- Health care claim status
- Enrollment and disenrollment in a health plan
- Eligibility for a health plan
- Health plan premium payments
- Referral certification and authorization

Compliance Dates

Covered entities had until April 14, 2003, to comply with the act's privacy regulations. Covered entities were to have complied with HIPAA standards for electronic claim submission (ANSI 837) by October 16, 2003, subject to fine, although a one-year delay was granted to "small" organizations.

2.6.3 Updating Practice Information

Excellus BlueCross BlueShield requires that providers **submit updated information whenever there are any changes to a provider or his/her practice**. This is necessary to keep directory and claims systems information current. This includes changes in:

- Provider Name
- Provider Tax ID
- Provider NPI
- Provider Taxonomy Codes
- Payment Address
- Directory Listing: that is, provider address, phone number, fax number and, for primary care providers who participate in managed care products, languages spoken and whether the practice is accepting new patients (open or closed)
- Service Addresses
- Changes in coverage arrangements
- When one or more practitioners join the group practice
- When one or more practitioners leave the group practice

To notify Excellus BlueCross BlueShield of such changes, complete a *Practitioner Demographic Changes* form, indicating what information has changed. The form is available at ExcellusBCBS.com/ProviderUpdateInfo. You may choose to complete either a paper or online update form. Website log in is required to access the online form. The completed paper

Practitioner Demographic Changes form may be faxed or mailed to our Provider File Maintenance department to the address or fax number included on the form.

> **Note:** Providers also may notify Excellus BlueCross BlueShield of changes in practice information by submitting a letter on office letterhead specifying what the changes are. Letters also should be faxed or mailed to Provider File Maintenance.

If a practitioner who is not already participating is joining a currently participating group practice, Excellus BlueCross BlueShield also requires that provider to complete an *Application for Practitioner Enrollment* form. This form is available at ExcellusBCBS.com/ProviderUpdateInfo.

2.6.4 Closing/Opening a Practice

In signing a participation agreement with Excellus BlueCross BlueShield, a participating physician agrees to accept as patients those members who elect to receive care from the physician, or those whom Excellus BlueCross BlueShield assigns to the physician. Providers are responsible for assessing practice capacity; if the physician's practice is at capacity, the physician may close his/her practice to new managed care patients.

However, a participating physician shall not close or reopen his/her practice to new patients without giving Excellus BlueCross BlueShield 90-day prior written notice. In all cases, a participating physician shall continue to permit a current patient who has other health coverage to designate the physician as his/her PCP in the event the patient chooses to enroll as a member of Excellus BlueCross BlueShield.

2.6.5 Access to Care

Excellus BlueCross BlueShield has established appointment availability standards to provide reasonable patient access to care. In addition, physicians who participate in Excellus BlueCross BlueShield's managed care programs are required to advise Excellus BlueCross BlueShield in writing of covering participating physician arrangements or changes to those arrangements, including situations in which physicians in the same office are covering for each other.

See the *Quality Improvement* section of this manual for additional information about Excellus BlueCross BlueShield's requirements for accessibility, including access to after-hours care.

2.6.6 Member Payments

Except in limited circumstances (see paragraphs headed *Charging for Copying of Medical Records*, and *Patient Financial Responsibility Agreement*), Excellus BlueCross BlueShield participating providers may not charge and/or collect a deposit from or seek any form of reimbursement from an Excellus BlueCross BlueShield member, or persons acting on the member's behalf, other than those permitted below:

Charges Permitted

Participating providers may collect applicable copayments, coinsurances, or unmet deductibles associated with covered services.

Note: Cost-sharing information (copayments, coinsurance and deductibles) for specific member contracts is available via the website inquiry methods. Providers may also call Customer Care for this information.

Charges Not Permitted

Participating providers cannot:

- Bill a managed care member for services above the applicable copay, with the exception of limited circumstances including but not limited to non-covered services. In these circumstances the member may be asked to pay for the full charge at the time the services are rendered.
- Charge a member when the member is covered by two health plans. For example, if Excellus BlueCross BlueShield is primary and a balance remains after Excellus BlueCross BlueShield has reimbursed its allowed amount for covered services, providers must bill the secondary carrier.
- Charge a member for administrative fees, such as completing claims forms or triplicate prescriptions that are standard overhead costs. Providers may bill a member if the member fails to show up for an appointment, but only if this policy is prominently displayed in the office and communicated to the physician's patients. Excellus BlueCross BlueShield does not pay for missed appointments.

2.6.7 Patient Financial Responsibility Agreement

Excellus BlueCross BlueShield encourages participating providers to ascertain, prior to supplying services to an Excellus BlueCross BlueShield member, whether those services are covered under the member's health benefit program. (See previous paragraphs for information about determining member eligibility.) This is important because, as stated above, participating providers may not charge or collect a deposit from or seek any form of reimbursement from an Excellus BlueCross BlueShield member, or a person acting on the member's behalf, other than the permitted copayments, coinsurances, or deductibles associated with covered services. Providers must notify the member in writing prior to providing a service that is not covered, informing the member that he/she will be liable for payment.

In situations where a member does not have a valid referral, or the member's eligibility for requested **outpatient** services cannot be determined because Excellus BlueCross BlueShield's member eligibility systems are not available, participating providers may elect to have the member complete and sign a *Patient Financial Responsibility Agreement*. (A sample form is available on the website or from Customer Care.)

Having the member sign the form may allow the provider to bill the member for services that Excellus BlueCross BlueShield did not cover because:

- The managed care member self-referred for the service, or
- The services were **not a covered benefit** under the member's benefit package, or
- The services were not within the scope of the provider's participation agreement, or
- The member had not completed the required waiting period for treatment of a pre-existing condition.

Once a member has signed a *Patient Financial Responsibility Agreement*, the provider should keep the form on file.

2.7 Medical Records

Excellus BlueCross BlueShield requires that participating provider medical records be kept in a manner that is current, detailed, organized, that complies with all state and federal laws and regulations, and that is accessible by the treating provider and Excellus BlueCross BlueShield. To support this requirement, Excellus BlueCross BlueShield has established Medical Record Documentation Standards. Information regarding these standards is included in the *Quality Improvement* section of this manual.

For medical record requests related to Medicare Advantage members, please see the *Medicare Advantage* section of this manual.

2.7.1 Access to Medical Records

By Excellus BlueCross BlueShield and Governmental Authorities

A participating physician or other provider must maintain medical records and provide such medical, financial and administrative information to Excellus BlueCross BlueShield as may be necessary to ensure compliance with applicable laws, rules, and regulations; and for program management purposes. Participating physician offices must:

- Maintain medical records in a manner that is individualized, current, organized, detailed, and confidential.
- Make records available to Excellus BlueCross BlueShield staff for review when requested.
- Make records available upon request of to NYS Department of Health, the Centers for Medicare & Medicaid Services or a local Department of Social Services (Medicaid only)
- Provide copies of patient charts to Excellus BlueCross BlueShield without cost, per the provider's participation agreement.

  Note: Medical record documentation auditing and reporting are part of "health care operations" as defined by HIPAA and thus do not require patient authorization for release of protected health information. For information about HIPAA, see the paragraph headed *HIPAA Compliance* that appears earlier in this section of the manual.

  According to the New York State Department of Health, New York state patient consent requirements are stricter than those found in the Health Insurance Portability and Accountability Act. Therefore, participating providers are required, as part of their participation agreements with us, to obtain patient authorizations or consents from our members directly. Offices obtain these authorizations as part of their routine administrative business practices. If this is not a routine part of your practice, please obtain such authorizations or consents for release of patient records if you have not already done so. For more information regarding privacy rule language, please visit http://www.hhs.gov/ocr/privacy.

By Members

Members have the right to see their medical records. Excellus BlueCross BlueShield's member handbooks state that any requests for medical records should be directed, in writing, to a member's physician. Each member age 18 or over, or an emancipated minor, must sign his or her own written request.

2.7.2 Charges for Photocopying Medical Records

Subject to the terms of a provider's participation agreement, a participating provider may not charge Excellus BlueCross BlueShield or the Department of Health for photocopying a patient's medical record. New York State Public Health Law Article 1, Title 2, Section 18 (2.e) states that providers may impose reasonable charges when a patient (*subject*) requests copies of his/her medical records, not to exceed 75 cents per page. However, members may not be denied access to their records due to inability to pay.

2.7.3 Advance Care Directives

Excellus BlueCross BlueShield encourages providers to discuss with members end-of-life care and the appointment of an agent to assume the responsibility of making health care decisions when the member is unable to do so. Information for members about advance care planning is available on the Excellus BlueCross BlueShield website.

Excellus BlueCross BlueShield's Medical Records Documentation Standards state that medical charts must include documentation indicating that adults age 18 years and older, emancipated minors, and minors with children have been given information regarding advance directives. See the *Quality Improvement* section of this manual for additional information about this requirement and about advance care directives.

> **Note:** Treatment decisions may not be conditional on the execution of advance directives.

2.8 BlueCard® Program

The BlueCross BlueShield Association sponsors the BlueCard Program, a program that helps make it possible for members covered by affiliated BlueCross BlueShield plans to maintain the protection of BlueCross BlueShield coverage even when they are away from the area served by their home plan.

Most BlueCross BlueShield members have a three-letter alpha prefix at the beginning of the member identification number. This prefix is critical to identifying the member's home plan and must be included on all claims. In addition, a suitcase logo located on member's identification card indicates that the claim for the out-of-area member should be submitted to the plan with which the provider participates (i.e., Excellus BlueCross BlueShield).

2.8.1 BlueCard Terms

- A **Home Plan** is the plan in which the patient is enrolled.
- A **Host Plan** (local plan) is the plan in the area where the services are rendered.

- **Prefix** is the three-letter alpha prefix in front of the member identification number. The prefix is critical to identifying the member's home plan and expediting claim processing.

2.8.2 Contacting the Home Plan

Providers should contact the Home Plan for the following:

- Membership
- Benefits
- Member cost-sharing amounts
- Referrals and authorizations

There are two ways to contact the Home Plan.

- **BlueExchange**. BlueExchange is the BlueCross BlueShield interplan system for select HIPAA transaction processing, including checking eligibility, checking claim status and requesting referrals. BlueExchange uses standard formats, secure and reliable plan-to-plan communications, common validation processes, and performance measurements. Providers can access BlueExchange via Excellus BlueCross BlueShield's website. (See the paragraphs regarding online inquiry systems.)
- **BlueCard 800# network**. Providers may call the BlueCard toll-free telephone number (see *Contact List*) to be routed to the member's Home Plan, after providing the alpha prefix.

2.8.3 BlueCard Rules

- A provider who participates with a local BlueCross BlueShield plan for indemnity, PPO, EPO, POS and Medicare Advantage products is also a participating provider for out-of-area BlueCross BlueShield members with these products. (See the *Introduction* section of this manual for definitions/descriptions of these types of products.)
- For HMO plans, an out-of-area authorization must be obtained from the member's plan in order for services to be covered (except for emergency services). There may be some exceptions to this policy, based on the member's contract.
- Providers may submit claims to their local BlueCross BlueShield plan (Host Plan) just as they would claims for locally enrolled subscribers.
    - Ancillary Claim Filing rules define the local BlueCross BlueShield plan as follows:
        - Independent Clinical Lab: The plan in whose service area the referring/ordering provider is located.
        - Durable/Home Medical Equipment & Supplies: The plan in whose service area the equipment was shipped to or purchased from (at a retail store).
        - Medical Specialty Pharmacy: The plan in whose service area the referring/ordering physician is located.
    - Air ambulance claim filing rules define the local BlueCross BlueShield plan as follows:

The plan in whose service area the point of pickup ZIP code is located. When the member's pickup location is outside the United States, U.S. Virgin Islands and Puerto Rico, claims should be filed to the BlueCard Worldwide® medical assistance vendor for processing through the BlueCard Worldwide Program. Providers must bill all BlueCross BlueShield claims, including BlueCard claims, with the three-letter alpha prefix. The letters in the prefix indicate the patient's Home Plan.

2.8.4 Contact Local Plan for BlueCard Claim Inquiries

There are three options for claim inquiries.

- Use BlueExchange via Excellus BlueCross BlueShield's website.
- Use the Request for Adjustment form provided by Excellus BlueCross BlueShield. (See the *Billing and Remittance* section of this manual.)
- Call Excellus BlueCross BlueShield's Customer Care (see *Contact List*)

2.9 Contents of the Excellus BlueCross BlueShield Website F

Excellus BlueCross BlueShield Website ExcellusBCBS.com	
Provider	**Coverage & Claims:** Check Eligibility, View Benefits & Coverage, Check Claims, Request Claim Adjustment, View Remittances & Statements, View Medical Policies
	Referrals & Auths: Check Referrals, Enter Referrals, Request Radiology Auths, Request Surgical & Medical Auths, Check Hospital Admissions, UM Appeals & Grievances, Search for Providers, Outpatient Procedure List
	Coding & Billing: Check Clinical Editing, Fee Schedules, Request an Adjustment, Sign Up for EFT, Claims Filing, Reading Your Remittance, Coding Tips & Information, Submitting Medical Records, ICD-10 Resources
	Prescriptions: Check Our Drug List, Prior Authorization & Step Therapy, Quantity Limits, E-Prescribing, TransactRx Medicare Vaccines, Prescription Drug Policies, Quantity Limits, Help Patients Save Money, Find a Pharmacy, SafeRx for Medicare Members
	Patient Care: Clinical Practice Guidelines, Quality & Performance, Preventative Health Programs, Managing Illness, View our Policies, Behavioral Health
	Education: Staff Training, Provider Manual, Fraud & Abuse, CME Credits, Patient Education Tools, Practice Design Resources, Health Information Technology, Preventing Obesity & Diabetes in Kids
	Contact Us: By Phone, By Email, By Mail, News & Updates, Compliance Notices, Update Your Practice Information, Credentialing & Recredentialing, Member Rights & Responsibilities, Print Forms
Member or Guest	**Your Account**: View Your Eligibility or Manage Your Policy, Change Your Address, Phone or Doctor, Manage Your Privacy and Confidentiality, Order an ID card *and More!*
	For Your Health: Healthy Rewards , 6,000+ Health Topics, Blue365 Discounts, Health Coaching, Stay Healthy, Managing Conditions, Advanced Care Planning, 24/7 Nurse Call Line
	Health Plans: Find Coverage for Yourself or Family, Medicare Plans, Dental Plans, High Deductible Health Plans, Plans for Small & Large Business, Flexible Spending Accounts
	Prescription Drugs: Check Our Drug Lists, Save Money on Your Prescriptions, Find a Pharmacy, Ask the Pharmacist, View Your Drug Claims, Manage Your Medications, Take as Directed
	Find a Doctor or Hospital: Find a Doctor, Find an Urgent Care Center, Find a Hospital, Find a Dentist, Find Other Providers , BlueCard® Coverage Wherever You Go, Away From Home Care® For HMO Members, Quality and Safety, Compare Hospital Quality
	Contact Us: By Phone, By Email, By Mail, Visit Us In-person, Frequently Asked Questions, News & Updates, Print Forms, Compliance Notices
Employer	Information for employers that offer Health Plan products to employees, includes the following: Enroll & Update, Shop & Buy, Engage Members, Contact Us
Brokers	Information for brokers who sell Health Plan products: Enroll & Update, Shop & Buy, Training & Resources, Engage Members, Commissions & Reports, Contact Us

List subject to change

Excellus BlueCross BlueShield Participating Provider Manual

3.0 General Provider Information

3.1 Provider Support F

Excellus BlueCross BlueShield has staff dedicated to assisting providers in doing business with Excellus BlueCross BlueShield.

3.1.1 Customer Care

Excellus BlueCross BlueShield encourages providers to use its online inquiry selections whenever possible. Otherwise, providers may call the Customer Care Department whenever they have questions.

(Customer Care telephone and fax numbers are listed on the *Contact List* in this manual.)

Customer Care representatives can answer most questions a provider might ask and, in situations where they can't provide an answer, they will direct a provider to the appropriate department. Call Customer Care to inquire about:

- Member eligibility and benefits
- Copayment and coinsurance information
- Referral and preauthorization status
- Claim status
- Medical policies
- Fee schedules
- Request for claims adjustment
- Request for appeal
- Coordination of Benefits (COB)
- Health Plan printed materials such as provider bulletins, provider newsletter or provider manual
- Any other provider-related issue

3.1.2 Provider Relations

Provider Relations representatives are liaisons between provider offices and Excellus BlueCross BlueShield.

Provider Relations representatives:

- Hold orientation sessions for participating providers and staff
- Educate providers on Health Plan policies and protocol
- Answer provider inquiries regarding provider participation agreements, reimbursement, incentive programs, etc.
- Assist providers with other complex problems or concerns
- Train office staff on use of available electronic tools
- Visit provider sites
- Host provider seminars

Contact information for Provider Relations representatives is available on Excellus BlueCross BlueShield's website or from Customer Care. From the provider page of the website, under *Contact Us*, select *Contact Information*, then *Find Your Local Representative* Scroll down to *Provider Relations Representatives* and select the appropriate region. This will bring you to a complete list of Provider Relations representatives for your region. Find the representative corresponding to your service area.

3.1.3 Provider Advocate Unit

Excellus BlueCross BlueShield has a Provider Advocate Unit (PAU) to address grievances submitted by physicians (MDs and DOs). The PAU is responsible for administering a process designed to provide a reasonable opportunity for a full and fair review of an initial coverage decision. The goal is to improve service and response to providers who disagree with Excellus BlueCross BlueShield's decisions.

Issues that qualify for submission of a grievance include those related to:

- Referral/Authorization process, not related to a medical necessity decision
- Administrative or medical policy changes/implementations
- Clinical editing
- Timely filing claims submission guidelines
- Benefit/contract coverage, not related to a specific member's care
- Claims payment disputes
- Fee schedule allowance/reimbursement
- Coding validation audits
- Scope of practice denials

To submit a grievance, a physician must submit the Provider Request for Grievance or Appeal form for all appeal or grievance (complaint) requests related to claims for our Commercial and Safety Net lines of business. Access the form on our website, ExcellusBCBS.com/Provider. Select "Print Forms" from the "Quick Links" section. The physician may submit written comments, documents or other information to support his/her position regarding the dispute.

The physician should submit his/her grievance within 90 calendar days of the date the physician received notification of the initial decision or administrative policy change or implementation, unless otherwise stipulated in the individual physician's participation agreement. Excellus BlueCross BlueShield will conduct a full review of the documents, *excluding any aspects of medical necessity*. Excellus BlueCross BlueShield may request medical records if needed to reach a determination.

For questions about the Provider Advocate Unit and the grievance process, contact Customer Care. (The Customer Care telephone numbers are on the *Contact List* in this manual.)

3.1.4 Provider Satisfaction Surveys

Excellus BlueCross BlueShield conducts hospital, physician and provider office manager satisfaction surveys at least annually. The surveys assess satisfaction with Excellus BlueCross BlueShield and are used to identify opportunities to improve services to the provider community and to members. Excellus BlueCross BlueShield develops action plans based on survey results, and assesses these plans to determine effectiveness.

3.2 National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that Health and Human Services (HHS) adopt a standard unique identifier for each individual health care provider, to be used with all payors. (For information about HIPAA, see the *Administrative Information* section of this manual.) On January 23, 2004, HHS published the final rule adopting the National Provider Identifier (NPI) as the standard unique identification number for health care providers.

3.2.1 National Provider Identifier Required on All Standard Transactions

Effective May 23, 2008, in order to be paid, each provider must include the NPI on all claims, electronic or paper.

ONLY NPIs are accepted on standard transactions (837, 835, 270/271, 276/277, 278), including both electronic and paper claims. Any transaction submitted without the NPI will be returned. Provider numbers used for billing prior to the implementation, such as Health Plan assigned numbers, are not accepted. (See the *Billing and Remittance* section of this manual for information on claim submittal.)

3.2.2 How to Obtain an NPI

The Centers for Medicare & Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign the unique identifiers. **Health plans are not responsible for the assignment of provider NPIs.**

It does not cost anything to apply for, or receive, an NPI, but **every provider must have one**. When applying for an NPI, providers must have their taxonomy codes available. (See below for additional information on taxonomy.)

Providers must apply for an NPI with the NPI Enumerator. The NPI Enumerator may be contacted by toll-free telephone, via the Internet or by U.S mail. Contact information is included on the *Contact List* in this manual. Look for *NPI Enumerator* on the alphabetical listing.

3.2.3 Taxonomy Codes

Taxonomy codes, also known as specialty codes, identify a provider's specialty category. A practitioner may have one National Provider Identifier (NPI) with multiple taxonomy codes, depending on the specialties in which he or she practices. It is suggested that a practitioner select the simplest, most generic taxonomy code to describe his or her specialty.

To view a list of taxonomy codes, please visit the Washington Publishing Company website at http://wpc-edi.com/codes/taxonomy. Please note that all claims must be submitted with taxonomy codes. Failure to include taxonomy codes on claims may result in incorrect payments.

3.2.4 Share NPI with Health Plan and Billing Agency

Providers must supply NPI information to Excellus BlueCross BlueShield. Those who have not already done so should contact Provider Relations. Offices that use a billing agency need to share NPI information with the agency. Excellus BlueCross BlueShield has communicated with vendors to ensure compliance with the requirements, as specified in the Trading Partner Agreement between the vendor and Excellus BlueCross BlueShield.

3.3 Credentialing and Recredentialing F

This section of the manual summarizes Excellus BlueCross BlueShield's credentialing and recredentialing policies. Copies of the complete policies are available upon request from Customer Care. (Customer Care contact information is on the *Contact List* in this manual.) Copies of policies are also available on the Excellus BlueCross BlueShield website www.excellusbcbs.com/wps/portal/xl.

3.3.1 Overview

Providers who wish to participate with Excellus BlueCross BlueShield must meet Excellus BlueCross BlueShield's credentialing requirements. Excellus BlueCross BlueShield credentials primary care physicians, most specialty physicians, certain other health professionals and specific types of facilities.

Excellus BlueCross BlueShield does not currently credential the following specialty physicians:

- Anesthesiologists who provide only basic anesthesia services (Anesthesiologists who provide pain management services must be credentialed.)
- Emergency Room (ER) physicians
- Hospitalists
- Locum Tenens

- Pathologists

Excellus BlueCross BlueShield is responsible for assuring the provision of accessible, cost-efficient, quality care to its members. To that end, Excellus BlueCross BlueShield's Credentialing Committee reviews the credentials of all providers who apply for participation. The Credentialing Committee is composed of community providers, Excellus BlueCross BlueShield medical directors, and other such members as Excellus BlueCross BlueShield may appoint. The committee is responsible, as a peer group, for the review of all practitioner credentials and the review of all credentialing and recredentialing policies.

Note: Excellus BlueCross BlueShield will not credential a trainee who does not maintain a separate practice from his/her training practice, nor does Excellus BlueCross BlueShield credential providers practicing on a limited permit. Excellus BlueCross BlueShield may not require credentialing of a provider who practices exclusively within an inpatient setting or freestanding facility, and who supplies health care services to an Excellus BlueCross BlueShield member only as a result of the member being treated at the facility.

Excellus BlueCross BlueShield makes credentialing decisions without regard to the applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients in whom the provider specializes. Excellus BlueCross BlueShield does not discriminate against providers who serve high-risk populations or who specialize in treating costly conditions.

Note: Excellus BlueCross BlueShield reserves the right to disapprove credentials in accordance with federal and state law and regulation.

The applicant has the burden of providing complete information sufficiently detailed for the Credentialing Committee to act. An applicant has the right upon request to be informed of the status of his/her application. The method of communication used by the applicant will determine the method of response. (For example, a phone inquiry will receive a phone response; a letter inquiry will receive a response by letter.)

Excellus BlueCross BlueShield will not provide benefits for services that a provider renders to a member covered under a program that requires providers to be credentialed until the provider is notified of Excellus BlueCross BlueShield's credentialing approval and execution of a participating provider agreement by both the provider and Excellus BlueCross BlueShield. Until he/she has received such an approval in writing and a participating agreement has been executed by both parties, a provider is not a member of the network and is not eligible for reimbursement. Providers must hold a member harmless if care is rendered prior to approval by the Credentialing Committee. Providers are recredentialed at least every three years.

Provider's Right to Review Credentialing Information

A provider has the right to review certain information Excellus BlueCross BlueShield uses when credentialing him or her. The information available for review is that obtained from

primary source organizations such as the National Practitioner Data Bank, state licensing boards, medical professional insurance carriers and hospitals. Any provider wishing to review his/her personal information obtained from these primary sources must submit a signed (original signature of requestor), written request to the Credentialing Department. (Credentialing Department contact information is included in the *Contact List* in this manual.)

The provider has the right to correct erroneous information submitted by another party. The provider must notify Credentialing Staff in writing within 30 days of discovering the erroneous information. Excellus BlueCross BlueShield will include the explanation and/or correction as part of the provider's application when it is presented to the Credentialing Committee for review and recommendation.

3.3.2 Web-Based System for Submitting Credentialing Information

Overview

Excellus BlueCross BlueShield participates in a web-based system that providers must use to submit credentialing and recredentialing information. The system incorporates a nationwide universal credentialing application offered through the Council for Affordable Quality Healthcare (CAQH). Called the *Universal Provider DataSource,* the system enables a provider to complete his/her credentialing application online, store the information in a database he/she controls and can update, and authorize participating health plans to view the data. In addition to physicians, this policy applies to all non-physician health care providers for whom Excellus BlueCross BlueShield has credentialing responsibilities, including:

- Acupuncturists
- Applied behavioral analysts
- Audiologists
- Certified diabetic educators
- Chiropractors
- Dentists
- Enterostomal therapists
- Genetic counselors
- Genetic counselors
- Licensed mental health counselors
- Massage therapists
- Nurse midwives
- Occupational therapists
- Optometrists
- Oral maxillofacial surgeons
- Physical therapists
- Podiatrists
- Psychiatric nurse practitioners
- Psychologists
- Registered dieticians
- Social workers
- Speech and language therapists

Note: For more information about the CAQH system, contact CAQH, Credentialing or Provider Relations. (For CAQH and Health Plan contact information, see the *Contact List* in this manual.)

Among the requirements of the credentialing process, physicians and non-physicians must:

- Maintain a practice within Excellus BlueCross BlueShield's service area.
- Demonstrate attainment of Excellus BlueCross BlueShield's specialty-specific requirements by providing copies of all applicable certificates regarding training, licensure, specialty certification and medical professional liability insurance.
- Possess and maintain at all times medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield. The provider must have a certificate of medical professional liability insurance that names the provider, documents the limits of liability and specifies the effective date and the expiration date.
- Possess and maintain at all times a valid state license and current registration.
- Possess and maintain at all times a valid Drug Enforcement Agency (DEA) Certificate, if applicable to the provider's specialty.
- Be a member in good standing with a Health Plan-affiliated Article 28 or Article 40 facility, if applicable. Exemptions to this requirement may be available upon request. All providers are required, by contract, to notify Excellus BlueCross BlueShield of any changes in their privilege status.
- Authorize release of information.
- Provide and update on an ongoing basis historical information regarding: physical or mental capacity impairments; criminal charges or convictions; loss, limitation or restriction of license; loss or limitation of DEA certification; loss or limitation of privileges in a hospital, facility, or managed care organization; professional disciplinary actions; or medical professional liability claims, among other information.
- Permit a site review of his/her office, if requested. See the paragraph headed *Office Site Review* in the *Administrative Information* section of this manual.
- Provide 24-hour coverage. In a managed care plan or a plan with managed care features, primary care physicians and specialists must provide continuous care of their patients through on-call coverage arrangements with other participating credentialed providers of the same or similar specialties. See the paragraph regarding *Access to Care* in the *Administrative Information* section of this manual.

Practitioner Credentialing

1. When a physician or other health care practitioner is a first-time applicant for participation with Excellus BlueCross BlueShield, Excellus BlueCross BlueShield will send the practitioner a form that the practitioner must complete and return. The form includes a place for the practitioner to enter his or her CAQH ID if already registered in that database.

2. After processing the information, if the practitioner is not already registered with CAQH, Excellus BlueCross BlueShield will send the practitioner a letter with his/her CAQH ID number and the address of the CAQH website where he/she must start the application process. The letter also will explain that CAQH will soon be mailing the practitioner a welcome kit.

   Excellus BlueCross BlueShield then will forward the practitioner's name to CAQH. This service is provided at no cost to the practitioner.

3. The CAQH welcome kit will include detailed instructions for creating an electronic application on the CAQH website. The kit will also include information about how to request and submit a paper application.

4. Once the practitioner completes the application and authorizes Excellus BlueCross BlueShield to view it, the practitioner's information will be available online through the Universal Provider DataSource.

   a. If the practitioner seeks to participate with another health plan that participates with the CAQH system, the practitioner may authorize that plan to view his/her information, thus eliminating the need to complete another credentialing application.

   b. Routinely, CAQH will ask the practitioner to update his/her information as necessary. A practitioner may also contact CAQH to update the information at any time.

   c. As required by Chapter 551 amendments to Public Health Law 4406-d(1) and Insurance Law 4803(a), Excellus BlueCross BlueShield will respond to a credentialing application within 90 days of receipt of the completed application. Excellus BlueCross BlueShield follows all applicable managed care legislation for any provider's credentialing application that is pending for more than 90 days. This includes notification to a provider when additional time is needed to complete processing of the application. Credentialing staff cannot process an incomplete application, if any information is missing, the practitioner will be notified as soon as possible, but no more than 90 days from receipt of the completed application.

   d. Credentialing staff shall notify the individual practitioner and/or the IPA(s)/Delivery System(s), if applicable, of the credentialing decision made by the committee within 30 days.

      Note: Practitioners must continue to notify Excellus BlueCross BlueShield directly in writing of changes to information, such as remit address, tax ID, etc. to keep claims processing systems accurate. This is done using the *Practitioner Demographic Changes form*, available on the website or by calling Customer Care.

Emergency Credentialing

Excellus BlueCross BlueShield may offer emergency credentialing to physicians or other health care practitioners in unique situations or where there is an urgent or emergent need for patients to access certain practitioners. An Excellus BlueCross BlueShield Medical Director will review all requests for emergency credentialing to determine whether approval should be granted. Emergency credentials, if granted, expires after 60 days.

Practitioner Recredentialing

Excellus BlueCross BlueShield may recredential practitioners at any time, but in no circumstances less frequently than every three years. When a practitioner is due for recredentialing, Excellus BlueCross BlueShield will use the CAQH application if the practitioner has reviewed and refreshed the data in the last 90 days. If the on-line application has not been refreshed recently, Excellus BlueCross BlueShield will contact the practitioner to request that the practitioner review, update and reattest to his or her CAQH application data.

3.3.3 Credentialing and Recredentialing Facilities

This section of the manual provides a brief overview of Excellus BlueCross BlueShield's facility credentialing process. For more information, call the Credentialing Department. (Credentialing Department contact information is on the *Contact List* in this manual.)

Excellus BlueCross BlueShield is committed to providing quality care and services to its members. To help support this goal, Excellus BlueCross BlueShield credentials and recredentials health delivery organizations with which it contracts. Health delivery organizations (as listed below) requesting participation in Excellus BlueCross BlueShield's provider network shall be required to meet established credentialing criteria based on service type. Excellus BlueCross BlueShield will not contract with health delivery organizations that do not meet the criteria for that provider type. Health Plan staff will review health delivery organizations at least every three years. Excellus BlueCross BlueShield will credential only licensed, regulated facilities.

Each health delivery organization must meet the criteria listed below. In situations where an organization does not meet the criteria, Excellus BlueCross BlueShield may reconsider the organization for participation following an on-site review.

A. Acute General Hospitals. At a minimum, the facility must provide inpatient, outpatient and emergency services and must have:
   a. Operating License and Certificate
   b. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or American Osteopathic Association (AOA); DNV Healthcare Inc. (DNVHC), Center for Medicare & Medicaid Services (CMS)
   c. Medicare Certification as issued by CMS
   d. Medicaid Certification as issued by the Department of Health, Education and Welfare
   e. Certification from the Office of Mental Health for Acute Care General Hospitals with Mental Health Services

f. Certificate of Insurance: general and medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield

B. Home Health Agencies including Certified Home Health Agencies and Licensed Home Care Service Agencies. At a minimum, an agency must make available the services of registered and licensed practical nurses, certified home health aides, as well as occupational, physical and speech therapists. The agency also must have:

a. Operating License and Certificate
b. Medicare and/or Medicaid Certification
c. Accreditation by JCAHO or the Accreditation Commission for Healthcare (ACHC): Organizations not accredited are requested to submit their most recent Department of Health Survey
d. Certificate of Insurance: general and medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield

C. Skilled Nursing Facilities. At a minimum, the facility must provide discharge planning services; nursing supervision and services by registered or licensed practical nurses, nurse's aides and occupational, physical and speech therapists; routine medical supplies; and semi-private room and board. At minimum, the facility must have:

a. Operating License and Certificate
b. Medicare and Medicaid Certification
c. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Continuing Care Accreditation Commission (CCAC). Organizations that are not accredited are requested to submit their most recent Department of Health Survey.
d. Certificate of Insurance: general and medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield

D. Freestanding Surgical Centers/Ambulatory Care Organizations. At a minimum, the facility must have:

a. Operating License and Certificate
b. Medicare and Medicaid Certification
c. Accreditation from a recognized accrediting body (e.g., JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC)
d. Certificate of Insurance: general and medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield

E. Freestanding Dialysis Center. At a minimum, the facility must have:

a. Operating License and Certificate
b. Medicare and Medicaid Certification
c. Accreditation from a recognized accrediting body (e.g., JCAHO or the Accreditation Association for Ambulatory Health Care [AAAHC])
d. Certificate of Insurance: general and medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield

F. Substance Use Treatment Centers. At a minimum, the facility must provide evaluation, intensive outpatient treatment and be medically supervised by a participating physician. At a minimum, the facility must have:

a. Operating License and Certificate.
b. Medicare and Medicaid Certification.
c. (i) For NY facilities, certification from OASAS to provide services defined in 14 NYCRR 819.2(a)(1) and Part 817.
(ii) For out-of-state facilities, licensure from a similar state agency or accreditation from the Joint Commission as an alcohol, substance use, or chemical dependency treatment program to provide the same level of treatment.
d. List of qualified individuals providing stated services.
f. Certificate of Insurance.

G. Community Mental Health Centers. At a minimum, the facility must provide evaluation, short-term treatment, and medical management services. At a minimum, the facility must have:

a. Operating License and Certificate
b. Medicare and Medicaid Certification
c. Certificate of Insurance: general and medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield
d. List of qualified individuals providing services and stated credentials

Note: When credentialing OMH-licensed, OMH-operated and OASAS-certified facilities, Excellus BlueCross BlueShield will accept OMH and OASAS licenses and certifications in place of any credentialing process for individual employees, subcontractors or agents of such providers. Excellus BlueCross BlueShield will collect and accept program integrity-related information as part of the credentialing process. Excellus BlueCross BlueShield requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in Medicare or Medicaid programs.

H. Inpatient Substance Use Facilities. At a minimum, the facility must have:

a. Operating License and Certificate
b. Medicare and Medicaid Certification
c. Certification from NYS Office of Alcoholism and Substance Abuse Services (OASAS)
d. Certificate of Insurance: general and medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield
e. JCAHO Accreditation
f. Certification from Office of Mental Health (OMH)

I. Inpatient Mental Health Facilities. At a minimum, the facility must have:

a. Operating License and Certificate

b. Medicare and Medicaid Certification
c. Certificate of Insurance: general and medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield
d. JCAHO Accreditation
e. Certification from Office of Mental Health (OMH)

J. Freestanding Sleep Study Centers. At a minimum, the facility must have**:**
a. Operating License and Certificate
b. Medicare and Medicaid Certification
c. Accreditation from American Academy of Sleep Medicine (AASM)
d. Certificate of Insurance; general and medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield

K. Freestanding Urgent Care Centers. At a minimum, the facility must have:
a. Joint Commission (JCAHO) accreditation or in process of achieving accreditation from JCAHO; an onsite review may be required, OR
b. Article 28 operating license and certificate issued by NYSDOH, OR
c. Accreditation by a recognized accrediting body (i.e. Urgent Care Center Accreditation (UCCA), American Academy of Urgent Care Medicine (AAUCM) AND
d. Independently practicing Nurse Practitioners must be credentialed, AND
e. All employed practitioners must be credentialed by Excellus BlueCross BlueShield and all Nurse Practitioners supervised by an on-site credentialed physician must be registered by Excellus BlueCross BlueShield and must maintain current, unrestricted licensure and be in good standing with state and federal bodies
f. Medicare and Medicaid certification
g. Certificate of Insurance; general and medical professional liability insurance in amounts specified by Excellus BlueCross BlueShield
h. Current unrestricted licensure of providers and nurse practitioners

L. Residential Treatment Facility
a. Operating License and Certificate
b. Medicare and Medicaid Certification
c. Certification by the Office of Mental Health (OMH), Office of Alcoholism, Substance Abuse Service (OASAS), The Joint Commission Accreditation, Health Care and Certification (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF) or equivalent licensing agency out of state.
d. Congruency with the New York State Department of Financial Services model language as the intensive level of residential care. **In New York state, Residential Treatment Facilities (RTFs) are covered for child and adolescent mental health per medical necessity guidelines, while Residential Treatment Centers (RTCs) are not a covered benefit.**
e. Certificate of Insurance

Excellus BlueCross BlueShield will conduct an on-site review if the above criteria are not met. On-site reviewers will verify that the organization:

- Has a current, active Quality Management Program
- Has a current, active Policy and Procedure Manual
- Holds Quality Management meetings appropriate to the organization
- Has indicators in place to address the measurement, action and frequency of reports/monitoring
- Monitors/reports member complaints and takes appropriate action
- Performs outcome studies
- Demonstrates that the individual member's plan of care corresponds to that prescribed by the member's physician

Excellus BlueCross BlueShield also conducts an interview with the organization's Director of Quality Program at the time of the on-site visit.

3.4 Registering Non-Credentialed Providers

Certain providers who elect to participate in Excellus BlueCross BlueShield's network, are not subject to credentialing but must, instead, be registered with Excellus BlueCross BlueShield. Currently, this group includes:

- Anesthesiologists who provide only basic anesthesia services. (Anesthesiologists who provide pain management services must be credentialed.)
- Emergency Room (ER) physicians
- Hospitalists
- Locum Tenens
- Observation Unit Physicians
- Pathologists
- Nurse Practitioners*, CRNAs, Pas
  *Not practicing independently

Procedures

1. An anesthesiologist, ER physician, hospitalist, locum tenens, Nurse Practitioner (not practicing independently), CRNA, PA or pathologist who wants to participate must contact Excellus BlueCross BlueShield through Customer Care. (For Health Plan addresses and phone numbers, see the *Contact List* in this manual.)

2. After discussion with an appropriate individual in the Network Management Department, the provider must complete an *Application for Non-Physician Health Care Practitioner* (available on Excellus BlueCross BlueShield website or from Customer Care) and attach:

   - A W-9 form
   - A signed copy of his/her license or registration
   - A signed participation agreement signature page
   - A copy of the face sheet from the applicable medical professional liability insurance policy.

- If applicable, a copy of his/her DEA registration.

3. The provider must mail or fax the materials to the appropriate regional address or fax number given on the last page of the form.

3.4.1 Registering Nurse Practitioners and Physician Assistants

Excellus BlueCross BlueShield requires that a nurse practitioner (NP), certified registered nurse anesthetist (CRNA) or physician assistant (PA) to be registered with Excellus BlueCross BlueShield so that NPs and PAs may be appropriately reimbursed for treating members. Where required, an NP collaborating agreement must be provided to Excellus BlueCross BlueShield. The supervising physician of a PA or CRNA must attest to being such on the registration form(s). Sixty days before an NP can begin billing under his/her own provider ID, the NP or the collaborating physician must register the collaborating agreement with Excellus BlueCross BlueShield by following these procedures. In the same time frame, a PA/CRNA who wishes to bill under his/her own provider ID must:

1. Complete a*n Application for Non-Physician Health Care Practitioner* available on Excellus BlueCross BlueShield's website or from Customer Care.

2. On the form, enter the required information for the NP/PA/CRNA and the collaborating/supervising physician whom the NP/PA/CRNA will be supporting.

   Note: To register collaborating/supervising agreements/relationships with additional physicians, attach a separate sheet. Include on that sheet the name of each additional physician and the other information specified in the Physician Information section of the form.

3. Attach photocopies of:

   a. Proof of medical liability insurance in amounts specified by Excellus BlueCross BlueShield.

   b. A written statement from the collaborating/supervising physician, affirming that he/she is the collaborating/supervising physician for this NP/PA/CRNA and, as required for NPs, that the appropriate agreement is in place.

      Note: If attaching a separate sheet listing collaborating/supervising agreements with other physicians, include photocopies of the above documents as associated with **each physician listed.**

4. If this NP/PA/CRNA has not previously registered a collaborating/supervising agreement/relationship with Excellus BlueCross BlueShield, also attach a photocopy of the NP/PA/CRNA's signed professional license or registration.

5. The NP/PA/CRNA must sign and date the form.

6. Fax or mail the form and its attachments (and the additional sheet and attachments, if necessary) to the attention of Provider Relations at Excellus BlueCross BlueShield address. (For Health Plan address and phone numbers, see the *Contact List* in this manual.)

3.4.2 Notifying Excellus BlueCross BlueShield when an NP/PA Agreement Ends

To the extent possible, Sixty (60) days before an NP/PA ends an arrangement with a collaborating/supervising physician, the NP/PA or the physician must notify Excellus BlueCross BlueShield **in writing.**

In the notification, include the NP/PA's national provider ID (NPI) as associated with the collaborating/ supervising physician, the physician's NPI, and the date the arrangement is to end. Mail the notification to Provider File Maintenance at Excellus BlueCross BlueShield. (Health Plan addresses and phone numbers are listed on the *Contact List* in this manual.)

3.5 Provider Termination and Suspension

Excellus BlueCross BlueShield has established a policy that describes the procedures associated with termination and suspension of providers. The policy is designed to advise providers of all notice and hearing rights afforded by the New York State Public Health Law, the New York State Insurance Law, and the federal Health Care Quality Improvement Act. In cases where a provider has a participation agreement with Excellus BlueCross BlueShield, to the extent that the agreement contains any additional rights with respect to terminations, or suspensions not set forth in the policy, such additional rights shall apply so long as they are not contrary to applicable law.

3.5.1 Cases Involving Imminent Harm to Patient Care

Where an Excellus BlueCross BlueShield Medical Director or his/her designee determines, at his or her sole discretion, that permitting a provider to continue to provide patient care services to members poses a risk of imminent harm to patient care, Excellus BlueCross BlueShield shall:

- suspend the provider's right to provide patient care services to members as described in the paragraph titled "Suspensions to Conduct Investigations" below.

OR

Except as set forth below, terminate the provider's participation agreement and revoke the provider's credentials, as applicable, without affording the provider a hearing as described in the paragraph titled "Notice and Hearing Procedures" later in this section of the manual. If the provider is a physician or dentist and the conduct is related to the physician's/dentist's competence or professional conduct, Health Plan may recommend termination of the physician's/dentist's participation agreement or revocation of the provider's credentials, as applicable, by referral to the Corporate Credentialing Committee. If the Corporate Credentialing Committee agrees and

propose to terminate the provider, Excellus BlueCross BlueShield shall afford the provider a hearing as described in "Notice and Hearing Procedures" later in this section of the manual. Notwithstanding the foregoing, where a Plan Medical Director determines in his or her sole discretion that the failure to take action in advance of affording the hearing procedures applicable to a proposed termination may result in the imminent danger to the health or safety of any individual, Health Plan may terminate the provider's participation subject to the subsequent provision of the hearing procedures applicable to a proposed termination.

3.5.2 Cases Involving Fraud *(as defined by the state in which the provider is licensed)*

Where there has been a determination of fraud, Excellus BlueCross BlueShield shall:

suspend the provider's right to provide patient care services to members as described in the paragraph titled "Suspensions to Conduct Investigations" below.

OR

Except as set forth below, terminate the provider's participation agreement and revoke the provider's credentials, as applicable, without affording the provider a hearing as described in the paragraph titled "Notice and Hearing Procedures" later in this section of the manual. If the provider is a physician or dentist and the conduct is related to the physician's/dentist's competence or professional conduct, Health Plan may recommend termination of the physician's/dentist's participation agreement or revocation of the provider's credentials, as applicable, by referral to the Corporate Credentialing Committee. If the Corporate Credentialing Committee agrees and propose to terminate the provider, Excellus BlueCross BlueShield shall afford the provider a hearing as described in "Notice and Hearing Procedures" later in this section of the manual. Notwithstanding the foregoing, where a Plan Medical Director determines in his or her sole discretion that the failure to take action in advance of affording the hearing procedures applicable to a proposed termination may result in the imminent danger to the health or safety of any individual, Health Plan may terminate the provider's participation subject to the subsequent provision of the hearing procedures applicable to a proposed termination.

3.5.3 Cases Involving Final Disciplinary Actions by State Licensing Boards or Other Governmental Agencies

Where a final disciplinary action has been rendered by any state licensing board or other governmental agency that impairs the provider's ability to practice, Excellus BlueCross BlueShield shall proceed in accordance with one of the following, as applicable:

suspend the provider's right to provide patient care services to members as described in the paragraph titled "Suspensions to Conduct Investigations" below.

OR

Except as set forth below, terminate the provider's participation agreement and revoke the provider's credentials, as applicable, without affording the provider a hearing as described in the paragraph titled "Notice and Hearing Procedures" later in this section of the manual. If the provider is a physician or dentist and the conduct is related to the physician's/dentist's competence or professional conduct, Health Plan may recommend termination of the physician's/dentist's participation agreement or revocation of the provider's credentials, as applicable, by referral to the Corporate Credentialing Committee. If the Corporate Credentialing Committee agrees and propose to terminate the provider, Excellus BlueCross BlueShield shall afford the provider a hearing as described in "Notice and Hearing Procedures" later in this section of the manual. Notwithstanding the foregoing, where a Plan Medical Director determines in his or her sole discretion that the failure to take action in advance of affording the hearing procedures applicable to a proposed termination may result in the imminent danger to the health or safety of any individual, Health Plan may terminate the provider's participation subject to the subsequent provision of the hearing procedures applicable to a proposed termination.

3.5.4 Termination for Exclusion from Participation in Medicaid or Medicare Program

If the New York State Office of the Medicaid Inspector General (OMIG) or U.S. Department of Human & Health Services Office of Inspector General (OIG) excludes or terminates a provider from participation in the Medicaid or Medicare programs, Excellus BlueCross BlueShield shall, upon learning of such exclusion or termination, immediately terminate the provider's agreement with respect to Excellus BlueCross BlueShield's Medicaid Managed Care product, or Medicare Advantage plans, and Excellus BlueCross BlueShield will no longer pay claims for the provider for services rendered to members with that coverage. The excluded provider will not be afforded a hearing as described in the paragraph titled "Notice and Hearing Procedures" later in this section of the manual.

3.5.5 Termination for other Reasons

Where Excellus BlueCross BlueShield proposes to terminate a provider's participation agreement and/or revoke a provider's credentials, as applicable, for any reason other than those described in the previous sections (e.g., failure to comply with Excellus BlueCross BlueShield's utilization management or quality management policies and procedures, failure to satisfy Excellus BlueCross BlueShield's credentialing/peer review/quality review standards), Excellus BlueCross BlueShield shall afford the provider a hearing as described in the following paragraphs.

Excellus BlueCross BlueShield may, in its sole discretion, implement an action or range of actions prior to termination, including but not limited to: corrective action plans with

monitoring as recommended by Quality Management; conditional, time-limited credentialing as approved by the Corporate Credentialing Committee; required continuing medical education; or mentoring by an appropriate peer.

3.5.6 Notice and Hearing Procedures

Any hearing afforded a provider shall be conducted in accordance with Excellus BlueCross BlueShield's *Practitioner Termination and Suspension Policy* as follows:

Notices

Excellus BlueCross BlueShield will send a provider written notice of any proposed termination. The written notice of proposed termination shall be personally delivered - or mailed by U.S. mail with return receipt requested - to the provider. The notice shall include:

1. A written explanation of the reasons for the proposed termination.
2. If appropriate, a statement that the provider has the right to request a hearing before a hearing panel appointed by Excellus BlueCross BlueShield.
3. A summary of the provider's rights at the hearing.
4. A time limit of not less than 30 calendar days within which to submit a written request for a hearing.
5. A time limit for a hearing, which must be held within 30 calendar days after the date of receipt of a request for a hearing, unless the parties agree otherwise.

Hearing Requests

1. Any request for a hearing must be in writing, and be personally delivered, or mailed by U.S. mail with return receipt requested, to the Medical Director.
2. The provider is entitled to only one hearing.
3. If the provider does not request a hearing in compliance with these rules, a proposed termination will be final, and the provider will have waived any right to a hearing or review under any applicable law.

Notice of Hearing

1. If the provider submits a written request for a hearing in compliance with these rules, Excellus BlueCross BlueShield shall give the provider a "Notice of Hearing." The *Notice* shall be in writing and shall state the place, time and date of the hearing, which date shall be within 30 days after the date of receipt of the hearing request, unless the parties agree otherwise. The Notice of Hearing shall be personally delivered or mailed by U.S. mail with return receipt requested to the provider.

2. The Notice of Hearing shall also state a list of the witnesses, if any, expected to testify at the hearing against the provider and that the right to a hearing will be forfeited if the provider fails to appear at the hearing without good cause. The provider shall also provide a list of witnesses and representatives to Excellus BlueCross BlueShield no less than five business days prior to the scheduled hearing.

Provider's Evidence at the Hearing

1. The Provider has the right to present witnesses at the Hearing. A list on any such witnesses shall be provided to the Plan at least five business days prior to the Hearing.
2. Any materials the Practitioner intends to use as evidence during the Hearing (e.g. relevant medical records, articles from peer-reviewed literature, statements of support from other physicians or providers), must be provided to Excellus BlueCross BlueShield at least five business days prior to the Hearing
3. Practitioner's failure to provide the list of proposed witnesses and/or evidence to be presented at the Hearing may result in exclusion of the witnesses and/or evidence from the Hearing. In the alternative and its sole discretion, Excellus BlueCross BlueShiel may delay the Hearing by a reasonable time if the witness list and/or evidence is not received within the time frame required; such delay will be communicated to the Practitioner in writing.

Conduct of the Hearing

If the practitioner submits a written request for a hearing in compliance with these rules, Excellus BlueCross BlueShield will appoint a hearing panel composed of three persons as follows: one clinical peer in the discipline and in the same or similar specialty as the practitioner under review and two other persons appointed by Excellus BlueCross BlueShield. The hearing panel may consist of more than three persons provided that the number of clinical peers in the panel shall constitute one-third or more of the total membership of the panel.

In its sole discretion, Excellus BlueCross BlueShield may appoint a Hearing Officer to facilitate the Hearing. The Hearing Officer will be an Excellus BlueCross BlueShield employee, and is not a voting member of the panel. The Hearing Officer ensures that the Hearing is conducted with due process, objectivity, impartiality, effectiveness and consistency.

1. The proponent (Excellus BlueCross BlueShield) leads with:
    a. The timeline of actions, notices and responses.
    b. The action(s) taken.
    c. Citations to policies, law, precedent and other rules that justify the action.
2. The respondent (practitioner) follows with:

a. Rebuttal to being informed in a timely manner of the adverse action, explaining the decision, or clear explanation of how to obtain a fair hearing.

b. Rebuttal with documents or witnesses to the facts that are the basis of the adverse action.

c. Proposed alternate penalties or conditions.

3. If one is appointed, the Hearing Officer must make decisions about evidence proposed for admission, identify the accepted evidence, only admit evidence applicable to the charges, decline testimonials and character witnesses, and permit both sides to present a case.

4. The committee must keep a record of the hearing, which includes the recording, transcript or summary; all admitted exhibits; committee decisions; committee notices; and orders.

5. The practitioner shall be afforded the right to have a record made of the hearing, and the practitioner may obtain a copy of the record of the hearing upon payment of any reasonable charges associated with the preparation and copying of the record.

6. The practitioner may submit a written statement to the hearing panel at the conclusion of the hearing.

Effective Date of Termination

1. If the provider does not request a hearing, the contract termination will become effective 60 days from the date the provider received the original notice of intent to terminate (i.e., written notice of proposed contract termination).

2. If the provider requests a hearing, and the hearing panel upholds the proposed action against the provider's credentials and termination of the participation agreement, the termination will become effective 30 days after the date the provider receives written notice of the hearing panel's decision, or 60 days after the date when the provider received the original notice of intent to terminate (i.e., written notice of proposed contract termination), whichever is later.

Reporting the Results of the Hearing

The decision of the hearing panel shall be reported to the Corporate Credentialing Committee. The minutes of the Corporate Credentialing Committee shall be reported to the board of directors. The hearing panel will render its decision in writing to the practitioner and the panel's written decision shall communicate reinstatement by Excellus BlueCross BlueShield, or provisional reinstatement subject to conditions set forth by Excellus BlueCross BlueShield, or termination.

3.5.7 Suspensions to Conduct Investigations

A Plan medical director may summarily suspend or restrict a practitioner's clinical privileges for a period not longer than 30 days to conduct an investigation in any case where a Plan medical director determines, in his or her sole discretion, that an Adverse Action may be warranted. Notwithstanding, in the case where a physician or dentist's conduct is related to his/her competence or professional conduct, a Plan medical director may summarily suspend or restrict clinical privileges:

(a) To conduct an investigation to determine the need for an Adverse Action for a period not to exceed 14 days, or

(b) Where a Plan medical director determines in his or her sole discretion that the failure to take such action in advance of affording the hearing procedures otherwise applicable to a Proposed Termination may result in the imminent danger to the health and safety of any individual, subject to the subsequent provision of the hearing procedures applicable to the Proposed Termination. Any suspension or restriction of clinical privileges pursuant to this paragraph shall be effective immediately upon notice to the practitioner.

Potential outcomes of such an investigation include Proposed Termination or initiation of a corrective action plan.

3.5.8 Non-Renewal

Upon 60 days' notice to the provider, or as otherwise set forth in a Health Plan provider participation agreement, Excellus BlueCross BlueShield may exercise a right of non-renewal at the expiration set forth in the participation agreement or at the expiration of the credentialing period, whichever is applicable.

3.5.9 No Retaliatory Terminations/Non-Renewals

Excellus BlueCross BlueShield will not terminate or refuse to renew a participation agreement solely because the provider has: (a) advocated on behalf of an enrollee, (b) filed a complaint against Excellus BlueCross BlueShield, (c) appealed a decision of Excellus BlueCross BlueShield, (d) provided information or filed a report to an appropriate governmental body regarding the policies or practices of Excellus BlueCross BlueShield which provider believes may negatively impact upon the quality of, or access to, patient care, or (e) requested a hearing or review.

3.5.10 Reporting to Regulatory Agencies

To the extent required by all applicable state and federal laws and regulations, Excellus BlueCross BlueShield shall report terminations or suspensions for cause of greater than 30 days to the appropriate regulatory agency, including without limitation, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the New York

State Department of Health's Office of Professional Medical Conduct, and the New York State Department of Education's Office of Professional Discipline.

The report must include the name, address, profession, and license number of the person being reported. The report shall also include a description of the action taken by Excellus BlueCross BlueShield with the specific reason for and date of the action. A Health Plan medical director will sign the report.

Causes for termination/revocation or suspension of greater than 30 days include but are not limited to:

- Termination of a provider for mental or physical impairment, misconduct, or impairment of patient safety
- Voluntary or involuntary termination to avoid imposition of disciplinary action
- Termination for a determination of fraud or imminent harm to patient care
- Information that reasonably appears to show a professional is guilty of misconduct

3.5.11 Transitional Care

Except for situations in which Excellus BlueCross BlueShield terminates the Participation Agreement without affording a Hearing in accordance with New York Public Health Law Section 4406-d(2)(a), BlueCross BlueShield shall permit Members to continue an ongoing course of treatment with the Practitioner during a transitional period of (i) up to ninety (90) days from the date the provider's contractual obligation to provide services to the member terminates, or (ii) if the Member has entered the second trimester of pregnancy at the time of the Practitioner's disaffiliation, for a transitional period that includes the provision of post-partum care directly related to the delivery.

3.6 Provider-Initiated Departure from Excellus BlueCross BlueShield

The term of a provider's participation with Excellus BlueCross BlueShield is specified in the participation agreement. In a standard participation agreement, the agreement is designed to remain in effect until either Excellus BlueCross BlueShield or the provider terminates the agreement under the provisions outlined in the agreement. (Written notice is required.)

- Providers who elect to terminate their participation agreement with Excellus BlueCross BlueShield for cause must give Excellus BlueCross BlueShield at least 60 days' notice per the agreement.
- Providers who plan to retire must notify Excellus BlueCross BlueShield 60 days prior to the date they intend to stop seeing patients.
- Upon the death of a provider, his/her representative should notify Excellus BlueCross BlueShield as soon as possible.

Send the notification to Excellus BlueCross BlueShield. (For Health Plan phone numbers and addresses, see the *Contact List* in this manual.)

3.6.1 Re-entry into Health Plan Following Resignation

Providers who wish to be considered for re-entry to the panel of providers permitted to treat Health Plan members must contact the Provider Relations Department to make that request. Excellus BlueCross BlueShield will consider readmittance based on established policy. Copies of this policy are available on the Plan's provider website.. (For Health Plan address and phone numbers, see the *Contact List* in this manual.)

3.6.2 Notifying Members Following Provider Departure

Health Plan Responsibilities

Within 15 days after receiving notification that a provider acting as a primary care physician will be disaffiliated with Excellus BlueCross BlueShield, or at least 30 days prior to termination date, Excellus BlueCross BlueShield will send a letter to managed care members under that provider's care. The letter will inform the member of the date on which the provider's contract was/will be terminated, encourage the member to select a new provider and provide notice of the member's right to request transitional care from the provider, if applicable.

Specialist Responsibilities

When an individual specialist physician or a specialty group terminates participation in Excellus BlueCross BlueShield, the specialist or specialty group must notify affected members of the termination prior to the effective date of the termination. In the event an individual specialist is terminated from a specialty group, the group must notify affected members prior to the effective date of the termination.

"Termination" shall include termination of the agreement between Excellus BlueCross BlueShield and the physician or group for any reason, or any other situation in which the physician or group is no longer available to see an affected member. "Affected members" refers to members enrolled in Excellus BlueCross BlueShield who are receiving ongoing treatment from the specialist physician or specialty group.

3.7 Provider Reimbursement

Reimbursement is based on standard payment methodologies utilized by Excellus BlueCross BlueShield for each provider type and line of business. Specific reimbursement is determined from the member's benefit package, the product lines in which the provider participates, and the terms of the provider's participating provider agreement.

Excellus BlueCross BlueShield's goal is to balance fair reimbursement to providers with Excellus BlueCross BlueShield's need to remain competitive and to keep care affordable. Inquiries regarding the reimbursement terms of a provider's participation agreement should be directed to Provider Relations. (See the *Contact List* in this manual.)

3.7.1 Payment in Full and Hold Harmless

When Excellus BlueCross BlueShield pays a participating provider directly for covered services, the provider must accept the payment as payment-in-full and must agree not to collect from or bill the member for anything except the permitted copayment, coinsurance, and deductible.

3.7.2 Fee Schedule

Excellus BlueCross BlueShield pays a participating provider for covered services provided to Health Plan members on the basis of a fee schedule pursuant to the terms and conditions of the provider's participation agreement. Physician reimbursement schedules are available on the secure section of our website, ExcellusBCBS.com/Provider. Reimbursement rates are mailed to non-physician professional providers (e.g., social workers; optometrists; chiropractors; physical, speech and occupational therapists, psychologists, etc.) If you are not a registered user of our website, it is very important for you to register in order to assess fee schedules online. Regarding patients who have high deductible health plans, providers can bill the patient at the time of service, if the deductible is not met. Ancillary institutional providers are reimbursed pursuant to the fee schedule provision included in their Provider Agreement.

Excellus BlueCross BlueShield deducts copayments, coinsurance, and deductibles from the amount to be reimbursed, as applicable. These amounts are determined from the member's benefit package, the product lines in which the provider participates, and the terms established in the provider's participation agreement with Excellus BlueCross BlueShield.

3.7.3 Reimbursement of Mid-Level Practitioners (NPs and PAs)

Regarding our Commercial and Medicare Advantage programs, Excellus BlueCross BlueShield will reimburse nurse practitioners (NPs) and physician assistants (PAs) (mid-level practitioners) at 85 percent of the physician fee schedule for evaluation and management, medicine, and procedural codes as applicable to all services within the scope of the licensure/registration of the individual NP/PA.

Exceptions to this are immunizations, vaccinations, injectable drugs, laboratory, radiology services, which are reimbursed at 100 percent of the physician fee schedule.

Excellus BlueCross BlueShield reimburses claims submitted by the NP/PA as part of the remittance paid to the associated collaborating/supervising physician. The health plan provides written notice of reimbursement for covered services within the scope of the NP/PA licensure. Please contact your Provider Relations representative to request a copy of the fee schedule pertaining to medical services that you provide.

For additional information regarding submitting claims for services provided by mid-level practitioners, see the *Billing and Reimbursement* section of this manual.

Excellus BlueCross BlueShield Participating Provider Manual

4.0 Benefits Management

Providers who agree to participate with Excellus BlueCross BlueShield have also agreed to cooperate and comply with the standards and requirements of Excellus BlueCross BlueShield's utilization management and other initiatives.

> **Note**: For the purposes of this section of the provider manual, the term "managed care" refers to those products that require the member to select a primary care physician (PCP) to coordinate his/her care. This may include obtaining authorization for a referral for services that the PCP cannot provide. The types of products that may have this requirement are HMO and point-of-service (POS).

4.1 Utilization Review F

> **Note:** This section **does not** apply to the utilization review process for Medicare Advantage products. For information about how Excellus BlueCross BlueShield conducts utilization review - called "organization determination" by the Centers for Medicare & Medicaid Services (CMS) - for Medicare Advantage products, see the *Medicare Advantage* section of this manual.

Excellus BlueCross BlueShield conducts utilization review to determine whether health care services that have been provided, are being provided, or are proposed to be provided to a member are **medically necessary.** Excellus BlueCross BlueShield has a medical policy defining *Medically Necessary Services*. The policy is available on Excellus BlueCross BlueShield's website or from Customer Care.

For Medicaid managed care (HMOBlue Option/Blue Choice Option and Premier Option) products, the New York State Department of Health requires the following definition of *Medically Necessary*:
Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

Excellus BlueCross BlueShield considers none of the following to be utilization review for medical necessity:

- A denial based on failure to obtain health care services from a designated or approved health care provider, as required under a member's agreement

- A determination rendered pursuant to the dispute resolution provision of Public Health Law section 2807(c) (3-a)
- A review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedures
- Any issue related to a determination of the amount or extent of payment, other than a determination to deny payment based on an adverse determination
- A determination of any coverage issues other than whether health care services are or were medically necessary or experimental/investigational
- A denial due to a contractual exclusion; or
- A denial for failure to obtain preauthorization where required

No Financial Incentives

Excellus BlueCross BlueShield has a process for reviewing health care services to ensure that they are evidence based, medically necessary, and being performed at the right level of care by qualified professionals. This process is called utilization management (UM) and it is conducted by licensed health care professionals and practitioners.

UM decision-making is based solely upon the application of nationally recognized clinical criteria, transparent corporate medical policies, and the existence of coverage. Excellus BlueCross BlueShield does not, in any way, encourage decisions that result in underutilization or reward UM decision-makers for denials of coverage or limits on access to care.

4.1.1 Utilization Review Criteria

Medical Necessity Determinations

Excellus BlueCross BlueShield conducts pre-service, concurrent and post-service reviews to determine whether the services requested are appropriate for the diagnosis and treatment of members' conditions. Medical necessity criteria are selected and/or developed and approved by Excellus BlueCross BlueShield medical management committees with input from participating physicians.

> **Note:** The fact that a provider has furnished, prescribed, ordered, recommended, or approved a service does not make it medically necessary; nor does it indicate that the service is covered.

Clinical Information/Case Documentation

In an effort to make an informed clinical decision, Excellus BlueCross BlueShield's Medical Services staff may request copies of selected portions of a member's medical record from all sources involved in the member's care (e.g. the member's primary care physician, a physician specialist, or an institutional or ancillary provider).

If the documentation supplied is insufficient or requires clarification, the Medical Services reviewer, Excellus BlueCross BlueShield Medical Director or designee may make a request

for additional information, either orally or in writing, to the requesting provider. If Excellus BlueCross BlueShield does not receive the requested additional information, Excellus BlueCross BlueShield's Medical Director will make a medical necessity determination based on the information available within the applicable time frame. (See the paragraphs entitled *Utilization Review Decision and Notification Time Frames* later in this section of the manual.)

Excellus BlueCross BlueShield will review the clinical information supplied against established clinical review criteria, Excellus BlueCross BlueShield standards, guidelines, and policies; and state and federal law and regulations.

Refer to the *Billing and Remittance* section of this manual, for additional information about submission of medical records.

Criteria Selection and Application

In performing utilization review, Excellus BlueCross BlueShield utilizes nationally recognized criteria such as InterQual® and Medicare medical coverage guidelines, as well as corporate medical policies and community-based criteria.

Criteria are reviewed with participating providers. Community-based criteria are developed using regional providers, who apply both regional standards of practice and nationally accepted standards. Medical Services reviewers use these standards to evaluate the medical necessity, level of care, and proposed alternative care settings for inpatient and outpatient services. Staff members apply Health Plan medical policies associated with the requested service. (See discussion about medical policies later in this section of the manual.)

Excellus BlueCross BlueShield's medical policies are available through the Provider pages on Excellus BlueCross BlueShield's website. Excellus BlueCross BlueShield utilization management criteria are available to participating providers, members and prospective members upon request from Customer Care. (For Health Plan telephone numbers, see the *Contact List* in this manual.)

Review of New Technology and Local Capacity

Excellus BlueCross BlueShield's mission includes making affordable medical care available as widely as possible throughout the community. Overuse of services and use of unproven technologies affect both cost and quality. Therefore, Excellus BlueCross BlueShield has established a process to review and manage both technology and capacity.

Capacity includes incremental increases in capital equipment (for example MRI scanners), programs (for example, birthing centers), approved technology that is new to the local area (for example, PET scans), and changes in the distribution of services within the service area.

Excellus BlueCross BlueShield will cover new technologies, services, and capacity *only* as approved and reviewed by corporate committees. New or incremental technology, programs or services that have not been reviewed through this process will not be eligible for coverage.

Participating providers who are planning to invest in new technologies, services, and/or added capacity should first verify that coverage will be available under Excellus BlueCross

BlueShield health benefit programs, and that the new technologies, services, and/or added capacity are consistent with Excellus BlueCross BlueShield's position on the community's need for additional capacity.

4.1.2 Types of Utilization Review

All utilization review processes follow the timelines shown on the chart, *UM Initial Determination Time Frames,* located on our website, ExcellusBCBS.com/Provider. (See the paragraphs entitled *Utilization Review Decision and Notification Time Frames* later in this section of the manual).

Excellus BlueCross BlueShield's Medical Services staff conducts utilization review to:

- Determine the medical necessity of the services utilizing clinical criteria;
- Determine appropriateness of the level of service and provider of service; and
- Identify and refer potential quality of care issues to the Quality Management Department.

Pre-Service Review

Excellus BlueCross BlueShield's Medical Services staff conducts pre-service reviews on all member services that, according to the individual member's contract, require such determinations before services are rendered.

A participating provider or a member may initiate a pre-service determination request by telephone, fax, web or written request, as directed by the terms of the specific benefit plan and the member contract. The staff will assess services in keeping with established preauthorization processes, the member's contract, and/or approved medical criteria. Cases not meeting criteria or requiring further evaluation are referred to a Medical Director or other clinical peer reviewer for determination. Licensed health care professionals (e.g., physicians) determine whether services are not medically necessary and/or are experimental/ investigational.

An Excellus BlueCross BlueShield reviewer or designee will contact the member and the requesting provider by telephone, to notify them of the determination. Excellus BlueCross BlueShield will follow this oral notification with a letter to the member and requesting provider.

Concurrent Review

Excellus BlueCross BlueShield's Medical Services staff conducts concurrent review for select services, to monitor the medical necessity of an episode of care during the course of treatment. Excellus BlueCross BlueShield usually conducts concurrent reviews through telephonic care coordination. Concurrent review is performed for select inpatient and outpatient care. Cases not meeting criteria or requiring further evaluation are referred to a Medical Director or other clinical peer reviewer for determination. Licensed health care professionals (e.g., physicians) determine whether services are not medically necessary and/or are experimental/investigational.

An Excellus BlueCross BlueShield reviewer or designee will contact the member and the requesting provider by telephone to notify them of the determination. Excellus BlueCross

BlueShield will follow this oral notification with a letter to the member and requesting provider.

Post-Service Review

Post-service review is the detailed analysis of an episode of care after the care has been rendered. Excellus BlueCross BlueShield staff may perform post-service review for both inpatient and outpatient services.

Cases not meeting criteria or requiring further evaluation are referred to a Medical Director or other clinical peer reviewer for determination. Licensed health care professionals (e.g., physicians) determine whether services are not medically necessary and/or are experimental/investigational. Written notices of adverse determinations are sent to members and rendering providers.

Urgent Requests

Providers requesting an urgent review of a case must document the specific reason for the request (e.g., application of the standard time frames would seriously jeopardize the life of the patient), so that Excellus BlueCross BlueShield can determine whether the request clearly meets the regulatory requirements for an urgent review.

Reconsiderations

Providers may call Excellus BlueCross BlueShield to request reconsideration of an adverse determination, when the provider recommended a service, but Excellus BlueCross BlueShield made no attempt to discuss the matter with the provider prior to making its decision. Reconsideration of a pre-service or concurrent review determination will take place within one business day of the request. Reconsideration decisions will be made by the same clinical peer reviewer who made the original determination, if he/she is available.

Reconsideration does not affect the right to appeal. (For example, an appeal may be initiated whether or not there has been reconsideration, or after reconsideration has occurred.) Reconsideration is a telephonic process, initiated through Customer Care.

4.1.3 Utilization Review Decision and Notification Time Frames

Excellus BlueCross BlueShield has established time frames for utilization review that meet state and federal regulations and accreditation standards. Notification to the member and the provider(s) of Excellus BlueCross BlueShield's decision is made in writing and by telephone, except that telephonic (oral) notice is not given in a post-service determination. Specific time frames and notification requirements for the different types of review are presented in the charts, *UM Initial Determination Time Frames*, available from the Provider page of Excellus BlueCross BlueShield's website, or by contacting Customer Care.

Note: Once Excellus BlueCross BlueShield has all the information necessary to make a determination, Excellus BlueCross BlueShield's failure to make a utilization review determination within the applicable time frame shall be deemed an adverse determination subject to appeal.

For appeal information, see the paragraphs under *Utilization Review Appeals and Grievances* later in this section of the manual.

4.1.4 Who Is Notified of Utilization Review Decisions?

If a request for pre-service or concurrent referral or preauthorization is approved, Excellus BlueCross BlueShield will provide telephonic notice to the requesting provider and member, and send written confirmation of the approval to the member, to the requesting provider, and to the providing specialist (or facility). If a pre-service or concurrent authorization is denied, Excellus BlueCross BlueShield will provide telephonic notice and send written notification of the denial to the member and the ordering physician. For pre-service denial cases, notice is not given to the proposed specialist or facility (due to HIPAA privacy regulations). For post-service cases, the same written notifications are sent to the same parties as listed above, but no telephonic notification is provided.

4.1.5 Written Notice of Initial Adverse Determination

An initial adverse determination is a determination made by Excellus BlueCross BlueShield or its utilization review agent that, based on the information provided, the admission, extension of stay, level of care, or other health care service is not medically necessary or is experimental/investigational and, thus, not covered. Time frames for notification are included in the chart, *UM Initial Determination Time Frames*, available on the Provider page of the Excellus BlueCross BlueShield website, or by contacting Customer Care.

All notices of initial adverse determination must include:

- The clinical rationale for the denial, including a reference to the criteria on which the denial was based
- A description of the actions to be taken (e.g., that Excellus BlueCross BlueShield will not provide coverage for the service at issue)
- Instructions for appealing the determination, including information describing the expedited and external appeal processes
- A description of the member's right to contact the Department of Health and/or Insurance Department, depending on the type of product, including toll-free telephone number
- An explanation of the right to external appeal of final adverse determinations
- Instructions for obtaining a copy of the clinical criteria used in making the determination
- A statement regarding the availability of the reviewer to discuss the denial
- A statement that the member's provider has the right to speak with a Medical Director if he/she has questions regarding the decision
- Instructions about how the member can obtain information about the diagnosis or treatment code related to the case

- Information about the right to a fair hearing, including aid to continue rights (for Medicaid managed care members)
- A statement that Excellus BlueCross BlueShield will not retaliate or take any discriminatory action if an appeal is filed.
- A statement that the notice is available in other languages and format for special needs and information on how to access these formats; and
- Any additional information required by Excellus BlueCross BlueShield to render a decision on appeal

If a member disagrees with a utilization review decision, or if Excellus BlueCross BlueShield does not make the decision within the specified time frame, the member may request an internal appeal. Excellus BlueCross BlueShield has standard procedures for responding to requests for appeals of adverse determinations made by a member, the member's authorized designee, or a provider. See the paragraphs under *Utilization Review Appeals and Grievances* later in this section of the manual.

4.2 Medical Policies

Excellus BlueCross BlueShield establishes and uses medical policies as a guide for determining medical necessity. Medical policies are either based on scientific evidence related to medical technology, or are intended to clarify coverage of services based on interpretation of member contracts.

All medical policies currently in effect are available on Excellus BlueCross BlueShield's website, along with an overview of the medical policy development and implementation process. Copies of the overview and of specific policies may also be obtained, upon request, from Customer Care. In addition, highlights of new and revised policies are included in the monthly provider newsletter. Questions and comments may be directed to the Medical Policy Coordinator. (For Excellus BlueCross BlueShield addresses and phone numbers, see the *Contact List* in this manual.)

Provider Participation in Medical Policy Development

Excellus BlueCross BlueShield Medical Policy Committee meets monthly to discuss and approve medical policies. Excellus BlueCross BlueShield encourages participating physicians to become involved in medical policy development, as follows:

- Participate in the Medical Policy Committee. For information about how to do so, contact the Regional Medical Director (see *Contact List*)
- Become involved in medical policy development. Each month, Excellus BlueCross BlueShield posts draft medical policies in the Provider section of the Excellus BlueCross BlueShield website for participating providers' review and comment. From the Provider page, select *View Medical Policies*. From the menu on the left, select *Medical Policies*, then *Preview & Comment on Draft Policies*

4.3 Primary Care Physicians and Specialists *(Managed Care Only)*

Excellus BlueCross BlueShield requires each member who is covered under a managed care health benefit program to select a primary care physician (PCP) as a condition of his/her membership.

A member's PCP is responsible for monitoring, supervising and coordinating the member's health care and providing access to 24/7 coverage. This may occur either by direct provision of primary care services or through appropriate referrals or preauthorizations that allow the member to receive health care services from other physician specialists and providers when medically necessary. (Referrals and preauthorizations are described later in this section of the manual) PCPs who participate with the Health Plan are expected to maintain a high standard of care and to uphold the commonly accepted professional and ethical standards of the medical field.

4.3.1 PCP Responsibilities

Primary care physicians include doctors in general practice as well as those specializing in internal medicine, family practice, and pediatrics. In certain situations, a member may select a specialty physician as a PCP. These situations are described later, in the paragraph entitled *Use of a Specialist as PCP*.

Primary care physicians:

- Provide all routine and preventive care
- Refer or request preauthorization for members to obtain:
  - Care from participating physicians and other health professionals
  - Laboratory tests, x-rays, and diagnostic tests
  - Inpatient care and treatment
  - Outpatient care and treatment
- Work with specialty physicians and other providers for continuity and coordination of care
- A member's PCP—not the PCP's office staff—is ultimately responsible for authorizing all referrals for that member. (See the paragraphs under the heading *Referrals*.) PCPs are also responsible for obtaining all consultation reports, lab tests and test results, for reviewing and noting the results in the medical record; and for documenting the treatment plan
- If a member is a patient of a behavioral health clinic that also provides primary care services, he or she may select a lead provider at the clinic as a PCP.
- For Medicaid enrollees, the member's PCP is responsible for conducting a Child/Teen Health Program (C/THP) screening for children and adolescents, and for conducting behavioral health screenings for all members, as appropriate.

4.3.2 Specialist Responsibilities

A specialist provides services to a member of a Excellus BlueCross BlueShield managed care program for a particular illness or injury, usually upon referral from the member's PCP. A participating specialist is responsible for rendering services to a member as ordered by the

PCP and/or reported on a referral form.

Participating specialists must adhere to Health Plan policies and procedures regarding preauthorization requirements for hospital admissions, home health care, durable medical equipment, and other specified medical care and procedures.

Should a specialist determine that an Excellus BlueCross BlueShield member requires services or care in addition to what has been specified by a member's PCP or that is beyond the scope of a referral, the specialist must obtain another referral from the PCP, unless a standing referral has been approved. In addition, there are other exceptions where a provider other than the PCP may refer. These are described later in this section of the manual.

4.3.3 Use of a Specialist as PCP

A member with a life-threatening or degenerative and disabling condition or disease that requires prolonged specialized medical care may receive a referral to a specialist who will be responsible for and capable of providing and coordinating the member's primary and specialty care. This type of referral must be made pursuant to a treatment plan approved by Excellus BlueCross BlueShield, in consultation with the primary care physician, the specialist, and the member. In no event will Excellus BlueCross BlueShield be required to permit a member to elect to have a non-participating specialist as a PCP, unless there is no specialist in the network.

4.4 Referrals *(Managed Care Only)*

When a managed care member requires selected specialty services that his or her PCP cannot furnish, the PCP may be required to "refer" the member to a participating Excellus BlueCross BlueShield specialist. *(Excellus BlueCross BlueShield also allows participating OB/GYNs to make any referral that a PCP can make.)* The PCP must request a referral and obtain an authorization referral number **before** the specialist provides services to the member. Referral requirements may differ, depending on the member's benefit plan. Providers must verify specific referral requirements for individual members.

4.4.1 Who Can Request a Referral?

Only the member's PCP, participating OB/GYN or a participating on-call physician may generate or update a referral for the member. There are some exceptions; *see* the chart *Who Can Generate and Update Referrals/Prior Authorizations?* available from the Provider page on Excellus BlueCross BlueShield website, or from Customer Care. On the website, go to *QuickLinks* and select *Print Forms.*

4.4.2 What Services Require a Referral?

Various specialty services provided outside of the PCP's office require a referral. For general referral requirements associated with a specific health benefit package, *see* the Referral Guidelines chart, available from the Provider page of the Excellus BlueCross BlueShield

website, or from Customer Care. On the website, go to *Online Services* and select *Referrals.*

To determine the eligibility of a specific member, inquire through one of Excellus BlueCross BlueShield's member eligibility inquiry systems, explained in the *Administrative Information* section of this manual.

Note: Excellus BlueCross BlueShield makes coverage decisions based upon the presence of a valid referral, the terms of a member's contract, and medical necessity. The presence of a valid referral does not guarantee payment. Payment is based on the member's contractual benefits in effect at the time of service.

4.4.3 If the Member Self-Refers

On occasion, a member may seek specialty services that require a referral without first contacting his/her PCP. In that instance, if the member is an HMO member, Excellus BlueCross BlueShield may deny benefits for the services rendered. A participating specialist must inform a patient who is an HMO member, *prior to treatment,* that the member will be liable for the payment due for these services. A participating specialist may not bill an HMO member for unpaid services provided without a valid referral number, unless the member has signed a *Patient Financial Responsibility Agreement*. A participating specialist who elects to see an HMO member without a valid referral may wish to have the member complete and sign a *Patient Financial Responsibility Agreement.* This is described in the *Administrative Information* section of this manual.

Claims for services rendered to an Excellus BlueCross BlueShield point-of-service (POS) member without a valid referral may be eligible for coverage under the member's out-of-network benefit, but may pay at a lower level. Payment will only be made if the care provided is medically necessary, and the member will be responsible for any applicable deductibles, coinsurance and any additional charges in excess of Excellus BlueCross BlueShield's allowance.

Members in Excellus BlueCross BlueShield PPO or indemnity plans do not need a referral for specialty services, but they may need preauthorization for selected services.

Female members in HMO plans may self-refer for OB/GYN care, in accordance with the benefit package. OB/GYN care includes:

- Two routine visits per year
- Care for acute gynecological condition and any follow-up care
- Prenatal care

Medicaid managed care members may choose to be seen by their primary care provider or county public health agency for the diagnosis and treatment of tuberculosis. A referral is not required before a Medicaid managed care member is seen for diagnosis or treatment of tuberculosis at a county public health agency.

Medicaid Managed Care members may self-refer to participating providers for:

- Obstetrics and gynecology services
- Dental services
- Eye care/vision services
- Family planning
- HIV and sexually transmitted infection screenings
- HIV prevention services
- Mental health and substance use disorder service assessments (this provision does not apply to assertive community health, inpatient psychiatric hospitalization, partial hospitalization, or home and community-based services)
- Smoking cessation services
- Maternal depression screenings
- emergencies

4.4.4 Standing Referrals

Excellus BlueCross BlueShield has a process in place that allows members who require ongoing care from a specialist to request a standing referral to that specialist. If Excellus BlueCross BlueShield, or the primary care physician in consultation with an Excellus BlueCross BlueShield Medical Director and the participating specialist, determines that a standing referral is appropriate for a member who requires ongoing care, Excellus BlueCross BlueShield will approve such a referral to a specialist.

The referral must be made pursuant to a treatment plan approved by Excellus BlueCross BlueShield, in consultation with the primary care physician and the specialist. The treatment plan may limit the number of visits and/or the period during which treatment is authorized. The specialist must provide regular reports to the member's PCP regarding patient care and status. In no event will Excellus BlueCross BlueShield be required to permit a member to have a standing referral to a non-participating specialist, unless there is no specialist in the network.

4.4.5 Out-of-Network Referrals

If Excellus BlueCross BlueShield's panel of providers does not include a health care provider with the appropriate training and experience to meet a member's particular health care needs, the member's PCP must submit a letter of medical necessity to request service from an out-of-network provider. Excellus BlueCross BlueShield may grant a referral, pursuant to a treatment plan approved by Excellus BlueCross BlueShield's medical staff in consultation with the primary care physician, the non-participating provider, and the member.

In such event, Excellus BlueCross BlueShield will arrange for the covered services to be provided at no additional cost to the member beyond what the member would otherwise pay for services received within Excellus BlueCross BlueShield's provider network. In no event shall Excellus BlueCross BlueShield be required to permit a member to receive services from a non-participating specialist except as approved above.

4.4.6 Referrals to Specialty-Care Centers

A member with a life-threatening or a degenerative and disabling condition or disease that

requires specialized medical care over a prolonged period of time may receive a referral to an accredited or designated specialty-care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by Excellus BlueCross BlueShield, in consultation with the primary care provider, if any, or specialist.

In no event will Excellus BlueCross BlueShield be required to permit a member to receive services from a non-participating specialty care center, unless Excellus BlueCross BlueShield does not have within the network an appropriate specialty care center to treat the member's disease or condition. Services must be provided pursuant to an approved treatment plan, and Excellus BlueCross BlueShield will arrange for the covered services to be provided at no additional cost to the member beyond what the member would otherwise pay for services received within the Excellus BlueCross BlueShield network.

4.4.7 Transitional Care When a Provider Leaves the Network

Note: The transitional care rights described in this section do not apply to patients of a provider who leaves an Excellus BlueCross BlueShield network without a right to a hearing under the provisions of the New York State Public Health Law.

Excellus BlueCross BlueShield will permit a member to continue an ongoing course of treatment with a provider during a transitional period: (i) of 90 days from the provider's termination, or (ii) through delivery and any post-partum care directly related to that delivery, if the member has entered the second trimester of pregnancy at the time of the provider's termination..

Excellus BlueCross BlueShield will authorize the transitional care described above only if the provider agrees to continue to accept the reimbursement rates in effect prior to the start of the transitional period as payment in full, and to comply with all of Excellus BlueCross BlueShield's policies and procedures, including, without limitation, quality management and utilization management programs.

4.4.8 Transitional Care for New Members

In the following circumstances, Excellus BlueCross BlueShield will permit a new member to continue seeing his/her previous health care practitioner for a limited time, even if that practitioner is not participating in Excellus BlueCross BlueShield:

- If, on the effective date of enrollment, the member has a life-threatening or a degenerative and disabling disease or condition for which he/she is in an ongoing course of treatment, he/she may continue to see a non-participating practitioner who is caring for him/her, for up to sixty days

- If, on the effective date of enrollment, the member has entered the second trimester of pregnancy, she may continue to see a non-participating practitioner who is caring for her through delivery and any post-partum care directly related to that delivery

4.4.9 How to Request a Referral

Providers may request a referral by computer, fax machine or telephone. Options may vary by Health Plan region. Telephone and computer tools for obtaining information from and providing information to Excellus BlueCross BlueShield are discussed generally in the *Administrative Information* section of this manual.

> **Note:** If the appointment for the specialist will occur within two business days, the provider should call in the referral and speak to an Excellus BlueCross BlueShield representative. The telephone number for referrals is included on the *Contact List* in this manual.

It is important to have all patient identification and referral information readily available before beginning.

Information Needed to Generate a Referral

1. Patient's name
2. Patient's birth date (for accurate identification)
3. Member ID number
4. Specialty provider to whom the member is being referred, including Provider ID
5. Diagnosis, including the ICD-CM code (if available)
6. Time period (duration of referral)
7. Number of visits (required for selected specialties, elective for others)

> **Note:** Non-emergency, out-of-area referrals require preauthorization. See the paragraphs on preauthorization below.

Requesting Referrals via Web

Provider offices may request referrals via the Excellus BlueCross BlueShield website, if the provider is registered for the service. Registration is discussed in the *Administrative Information* section of this manual.

To get to referrals from the provider page on the website, select *Online Services* from the menu in the yellow bar at the top of the screen, then click on *Referrals* in the menu on the left.

Requesting Referrals via Fax

To request a referral by fax, the provider should complete the referral fax form and fax it to the number on the form. The referral fax form is available from the provider pages of Excellus BlueCross BlueShield's website or from Customer Care. To get to the form from the provider page of the website, select Print Forms from the bar menu at the bottom, then click on the form under *Benefits Management* heading. **It is important to fill out the referral form completely.**

Requesting Referrals via Telephone

> **Note:** If the appointment for the specialist will occur within two business days, the provider should call in the referral. The telephone number for referrals is included on the *Contact List* in this manual.

4.5 Preauthorization F

Excellus BlueCross BlueShield requires that it review certain services in advance to determine if the services are medically necessary, appropriate for the specific member, and experimental and/or investigational. Before providing these services, a provider must request authorization from Excellus BlueCross BlueShield, which initiates the review.

Preauthorization requirements differ, depending on the member's benefit plan and the applicable utilization management program. Providers should review the preauthorization guidelines (available on Excellus BlueCross BlueShield's website or from Customer Care) for specific services that require preauthorization. Providers should always verify preauthorization requirements for the member's health benefit program, and check benefits and eligibility via one of the methods described in the *Administrative Information* section of this manual.

Excellus BlueCross BlueShield may deny claims for services that require preauthorization but were not preauthorized. For information on how to dispute decisions, see the paragraphs under *Utilization Review Appeals and Grievances*.

Excellus BlueCross BlueShield makes coverage decisions based upon the presence of an authorization, the terms of a member's contract and medical necessity. The presence of an authorization does not guarantee payment. Payment is based on the member's contractual benefit in effect at the time of service.

4.5.1 Who Can Request a Preauthorization?

Under managed care plans, only the member's PCP (or a specialist with a valid referral from the PCP, if required) may request the required preauthorization. (For exceptions, see the chart, *Who Can Generate and Update Referrals/Prior Authorizations?,* available on Excellus BlueCross BlueShield's website or from Customer Care. On the website, from the Provider page, click on *Print Forms* at the bottom.

Under non-managed care plans, the member's PCP or the treating provider may request preauthorization.

4.5.2 How to Request a Preauthorization

Providers may request preauthorization by computer or telephone. Options may vary by Excellus BlueCross BlueShield region. Telephone and computer tools for obtaining information from and providing information to Excellus BlueCross BlueShield are discussed in general in the *Administrative Information* section of this manual.

It is important to have all patient identification and clinical information readily available before beginning.

Information Needed to Request Preauthorization

1. Patient's name
2. Patient's birth date (for accurate identification)

3. Member ID number
4. Requesting physician
5. Servicing provider
6. Diagnosis, including the ICD-CM code (if available)
7. CPT/HCPCS
8. Time period
9. Number of visits/quantity requested

Requesting Preauthorization by Telephone

- Call the number listed under Preauthorization on the *Contact List* in this manual
- Inform the representative that you are requesting preauthorization
- Provide all information requested
- The representative will enter the preauthorization request and, if required, forward it to a nurse in Excellus BlueCross BlueShield's Medical Services Department for review
- If you can provide all necessary clinical information over the telephone, you may choose to have your call forwarded to the Medical Services review nurse or designee for clinical review. You also have the option of faxing requested clinical documentation to the Medical Services Department for review. The representative will provide the appropriate fax number at the time of your call
- Once the utilization review nurse has all the necessary clinical information, a decision will be made within the time frames listed on the chart *UM Initial Determination Time Frames*, available from the Provider page of Excellus BlueCross BlueShield's website, or from Customer Care. (See the paragraphs under the heading, *Utilization Review,* at the beginning of this section of the manual for more detail.)

Requesting Preauthorization by Computer

Provider offices may also request preauthorization via the Excellus BlueCross BlueShield website, if the provider is registered for this service. Preauthorization for concurrent services must be done by telephone. Registration information is included in the *Administrative Information* section of this manual.

To get to preauthorizations from the Provider page on the website, select *Referrals and Auths* from the menu in the yellow bar at the top of the screen, then click on *Request Authorizations*.

Provider offices also may request preauthorization for specific services via Clear Coverage, our electronic entry tool for preauthorization.

Special Methods of Requesting Preauthorization for Selected Services

Please note that there are special methods to request preauthorization for Imaging Studies, Physical Therapy, Occupational Therapy, and selected Medical Drugs. See the separate paragraphs below that are devoted to these services.

4.5.3 What Services Require Preauthorization?

Services are subject to preauthorization based on the individual member's contract. See the Preauthorization Guidelines, available on Excellus BlueCross BlueShield's website or from Customer Care, for preauthorization requirements for most managed care health benefit programs. On the website, from the Provider page, go to *Referrals and Auths* and click on *View Referrals & Authorization Guidelines*.

Preauthorization requirements for non-managed care health benefit programs may be listed on the member's ID card.

To determine the benefit requirements for a specific member, inquire through one of Excellus BlueCross BlueShield's member eligibility inquiry systems, explained in the *Administrative Information* section of this manual.

4.5.4 Reversal of Preauthorization Approval

Under New York State law, a managed care organization (MCO) (such as Excellus BlueCross BlueShield) may reverse approval of a preauthorized treatment, service or procedure when:

- The relevant medical information presented to the MCO or utilization review agent upon retrospective review is materially different from the information that was presented during the preauthorization review; and
- The relevant medical information presented to the MCO or utilization review agent upon retrospective review existed at the time of the preauthorization, but was withheld from or not made available to the managed care organization or utilization review agent; and
- The MCO or utilization review agent was not aware or the existence of the information at the time of the preauthorization review; and
- Had the MCO or utilization review agent been aware of the information, the treatment, service, or procedure being requested would not have been authorized. This determination is to be made using the same standards, criteria and/or procedures as used during the preauthorization review.

Excellus BlueCross BlueShield may also reverse or revoke preauthorization when it has determined that:

- There is evidence of a fraudulent request
- The time frame of the authorization has expired
- There is a change in the status of the provider from participating to non-participating (subject to the state laws governing continuity of care)
- There is a change in the member's benefit plan between the approval date and date of service
- There is evidence that the information submitted was erroneous or incomplete
- There is evidence of a material change in the member's health condition between the date the approval was provided and the date of treatment that makes the proposed treatment inappropriate for the member

- The member was not a covered person at the time the health care service was rendered. (Exceptions may apply if the member is retroactively disenrolled more than 120 days after the date of service.)
- The member exhausted the benefit after the authorization was issued and before the service was rendered
- The preauthorized service was related to a pre-existing condition that was excluded from coverage
- The claim was not timely under the terms of the applicable provider or member contract

4.5.5 Preauthorization for Imaging Studies

In addition to managed care health benefit programs, many other benefit plans may require preauthorization for selected elective outpatient imaging studies. The list of imaging studies requiring preauthorization is available from Customer Care.

Ordering physicians must request preauthorization for selected imaging studies for those members who require it, **before** sending the member for the study.

Providers may request preauthorization by computer, by fax or by telephone. See the *Contact List* in this manual for the appropriate web address, fax and telephone number.

Ordering physicians should make certain that all clinical information is available, including:

- Patient's name, date of birth and member ID number
- Ordering provider's name, Provider ID number, fax number and telephone number
- Rendering provider's information, including facility name, fax number and telephone number
- The CPT code and/or description of the test requiring authorization
- Patient data relevant to the request, such as: signs and symptoms, test results, medications, related therapies, dates of prior imaging studies, etc.

All requests will be reviewed within the appropriate time frame. If a request is approved, the requesting physician will be notified by telephone and in writing, and an authorization number will be provided. The physician should contact the member with the approval and testing schedule. Excellus BlueCross BlueShield also will notify the member by letter.

- Preauthorizations for imaging studies are valid for 45 days from the date of approval.
- If a request is not approved, then the member and the ordering provider are notified by telephone and in writing. The letter will include the rationale for the decision, as well as information regarding the appeals process.

Claims for imaging services will process according to the member's health benefit program that is effective on the date of service. Failure to obtain preauthorization will likely result in payments being denied, and the member may be held harmless.

4.5.6 Preauthorization for Physical Therapy and/or Occupational Therapy

Providers requesting preauthorization for physical and/or occupational therapy must utilize Clear Coverage for services requiring preauthorization, including the following circumstances:

- The request is for additional visits.
- The request is for a different diagnosis or to see a different practitioner.
- The request is for direct access (without being referred by a physician).

Additional Visits

If the physical or occupational therapist feels that more visits are warranted, he or she should request them prior to the last authorized visit, using Clear Coverage.

If Excellus BlueCross BlueShield determines that the request for additional visits does not meet Excellus BlueCross BlueShield criteria, Excellus BlueCross BlueShield will ask the physical therapist or occupational therapist to send all case note documentation, including objective, measurable data and an updated physician order. Excellus BlueCross BlueShield will review patient progress over the previous two-week interval. The case will be presented to an Excellus BlueCross BlueShield Medical Director for review. The Medical Director may authorize additional visits or deny coverage for further services.

If treatment is denied, the member or his/her representative may initiate an appeal of this decision. See the paragraphs entitled *Utilization Review Appeals and Grievances* later in this section of the manual for information about appeals.

Different Diagnosis or Different Practitioner

If a physical therapist or occupational therapist requests another authorization while an earlier authorization is still active (due to a different diagnosis or a different practitioner), Excellus BlueCross BlueShield requires completion of the request via Clear Coverage. When the provider calls for the authorization, if the representative finds an authorization still open, he/she will request that the provider complete the request via Clear Coverage.

Direct Access

Physical therapy providers may request their own preauthorization for an initial 10 visits over 30 days in accordance with New York State requirements for direct access to as deemed appropriate for physical therapy. To qualify for a direct access preauthorization, the provider must be in clinical practice for a minimum of three years, must inform the member in writing that insurance may not pay for the therapy and that the member may only be seen for 10 visits over a 30-day period, whichever comes first.

4.5.7 Medical Drug Preauthorization

Medical drugs are drugs that are administered by a health care provider in the office, at an

infusion center, at an outpatient facility or by nurses in home care. Medical drugs are covered under a member's medical benefit. In contrast, prescription drugs are drugs that can be self-administered and are covered under a member's prescription drug benefit.

Some medical drugs may also fall into the category of Medical Specialty Drugs due to limited distribution or other unique characteristics. Medical drugs may be obtained through a contracted specialty pharmacy or purchased by the provider and billed to Excellus BlueCross BlueShield.

Preauthorization is required for some medical drugs. Preauthorization for medical drugs is handled through the Medical Specialty Medication Review Program. Additional information is available on Excellus BlueCross BlueShield website or from Customer Care. From the Provider page of the website, select: *Prescriptions > Drug Policies* to see the policy criteria. From the Provider home page, click on *Manage Medications*, then *Medical Specialty Drugs* to see a list of the drugs that require preauthorization. This list is updated frequently as new drugs are introduced to the market.

The Prior Authorization forms are available at:
ExcellusBCBS.com/ProviderPrescriptions

> **Note:** Claims will deny or suspend for review across all lines of business for provider-administered medications that require authorization unless preauthorization has been obtained.

Refer to the *Pharmacy Management* section of this manual for additional information related to medical drugs including preauthorization requirements, the Medical Specialty Medication Review Program, and Specialty Pharmacy options related to obtaining medical and medical specialty drugs.

4.6 Emergency Care Services (In-Area and Out-of-Area) F

A referral is not required for treatment of an emergency medical condition in an emergency room. An **emergency medical condition** is defined as a medical or behavioral condition, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; (d) serious disfigurement of such person; or (e) a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act. **Emergency medical service** is defined as a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition; and within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

4.7 Inpatient Admissions F

Many of Excellus BlueCross BlueShield's health benefit programs require preauthorization/notification for inpatient admissions, excluding maternity and emergency room services. Some health benefit programs do not include a benefit for skilled nursing facilities, inpatient acute rehabilitation or inpatient chemical dependency services. It is important that providers verify eligibility for non-emergency inpatient admissions prior to admitting.

Excellus BlueCross BlueShield may deny claims for services that require preauthorization but that were not preauthorized. For information on how to dispute decisions, see the paragraphs following the heading, *Utilization Review Appeals and Grievances*.

No preauthorization is required before emergency services rendered by a hospital, but hospitals must notify Excellus BlueCross BlueShield of emergency admissions within the following time frames:

- During normal business hours, within 24 hours of rendering services or next business day
- Over a weekend, within 48 hours of rendering services or next business day
- Over a holiday, within 72 hours of rendering services or next business day

For members whose health benefit programs that do not require preauthorization for inpatient admissions, Excellus BlueCross BlueShield encourages facilities to notify Excellus BlueCross BlueShield before admitting a member, or within 48 hours of admitting a member for emergency care. This is to coordinate care and facilitate claims processing.

4.7.1 Notifying Excellus BlueCross BlueShield of an Admission

To notify Excellus BlueCross BlueShield of an inpatient admission, facilities may use any of the methods described in the *Administrative Information* section of this manual. Providers should have the following information readily available:

1. Member name and date of birth
2. Member ID number
3. Name of attending physician
4. Name of hospital or facility
5. Date of admission
6. Diagnosis and pertinent medical information

4.7.2 Physician Referrals During Inpatient Stay

In **most** instances, Excellus BlueCross BlueShield does not require physicians to obtain a separate referral for managed care members for inpatient medical care, inpatient consultations, inpatient psychiatric care, or nursing home visits *during* an approved admission. These services are normally considered part of Excellus BlueCross BlueShield's

authorization for the admission. However, the attending physician should obtain preauthorization for surgery or other care not defined above.

After Discharge

In addition, depending on the health benefit program, physicians and/or other service providers may need a referral from the member's PCP for continuing care following discharge.

4.8 Site of Service: Inpatient versus Outpatient F

Several national standards indicate that many surgical procedures are most appropriately rendered in an outpatient setting, such as the outpatient department of a hospital, a freestanding ambulatory surgery center, or a physician's office. Excellus BlueCross BlueShield has established a list of these procedures. See the *Outpatient Procedure List* available on Excellus BlueCross BlueShield's website or from Customer Care.

Except in special circumstances, these procedures will be covered only when performed in an outpatient setting. **Any facility or individual provider who feels that the patient has a special medical condition or complication that requires an inpatient stay for a listed procedure should contact Excellus BlueCross BlueShield for authorization prior to scheduling the procedure.**

If a required authorization is not obtained in advance, Excellus BlueCross BlueShield may deny payment for the services.

If the patient is already hospitalized and requires a surgical procedure that is on the Outpatient Procedure List, the procedure is covered as part of the inpatient stay if it is deemed medically necessary that the patient remain hospitalized.

4.9 Care Coordination F

One aspect of Excellus BlueCross BlueShield's utilization management function is to coordinate the care of select hospitalized members enrolled in specific health benefit programs. The goal is to ensure that the member receives the appropriate level of care in the hospital and experiences a smooth transition to appropriate post-discharge services (e.g. home care, case and disease management programs).

While hospital medical staff remains responsible for all medical care and treatment decisions, Excellus BlueCross BlueShield staff is available to make timely referral into services and programs that could benefit the patient after discharge, or while still hospitalized.

4.10 Member Care Management F

Note: Applies to all Excellus BlueCross BlueShield members, unless the member's contract provides otherwise.

4.10.1 Member Care Management Programs

Excellus BlueCross BlueShield provides care management services at no additional cost to members. Members benefit from programs that focus on preventive care and management of chronic and complex conditions.

4.10.2 Member Care Management Program Components

Components

Preventive Health programs provide useful information about important preventive measures that can be taken in order to avoid the onset of chronic or acute illness. Resources are provided to assist members in practicing healthful behaviors such as exercise, health diet and essential preventive screenings and immunizations. Members can access online materials such as brochures, fact sheets and a Healthwise® Knowledgebase that includes information on more than 6,000 health topics.

Chronic Care Management is a program that assists members who have chronic illnesses to better manage and control their diseases. Members may receive disease-specific mailings, access web-based information, utilize self-care resources, and participate in telephonic education. The goal of this program is to improve the self-management skills of members who have chronic illnesses such as diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease, asthma, and co-morbid depression. The program emphasizes member education, self-management and self-monitoring skills, and support for the member's efforts toward a healthy lifestyle.

Complex Care Management is a telephonic program that helps members who have complex illnesses to maintain or improve their health and quality of life. Care managers guide a member through the complexities of the health care system while supporting the physician's treatment plan for that member. Care managers promote wellness and member autonomy through advocacy, communication, education, coordination of service resources, and assistance in investigating solutions to members' concerns. Care managers do this by collaborating with physicians and other providers, specialists, community resources and internal resources on behalf of the members and their families.

Advantages of Member Care Management Programs:
Chronic Care Management

- Free educational packets and self-monitoring tools help members manage their own conditions
- Individual instruction and coaching by telephone through a series of scheduled contacts based on a standard curriculum are available to members
- Flexible service hours are offered to meet the member's needs
- Members receive encouragement to adhere to the physician's treatment recommendations regarding medication, physical activity, nutrition, and self-monitoring

- Care management offers links to available community services

Complex Care Management

- Interventions promote directions physicians give to their patients
- Programs offer care coordination role to physician offices
- Patients can receive nurse intervention as frequently as needed to support the treatment plan even if they don't qualify for home care services
- Care for chronic and high-risk conditions requires appropriate medication compliance—care management addresses concerns of medication costs, increasing opportunities for adherence
- Care management offers links to available community resources

4.10.3 Policies and Procedures

- Members who may benefit from case management are identified by their primary care physicians or through risk assessment or other internal mechanism
- Each member's Plan of Care is developed in collaboration with the member, the member's physician, an RN case manager, and specialty care physicians, as appropriate
- Members must meet defined discharge criteria, before case management is discontinued

Procedures

Excellus BlueCross BlueShield's Member Care Management Department has established criteria for identifying individuals who may appropriately be considered for care management services. These criteria are available upon request from Customer Care. Physicians also may refer a member to the Care Management programs by calling Excellus BlueCross BlueShield's central intake number 1-800-434-9110 and providing the following information:

- Member's name and ID number
- Referring physician's name and phone number
- Primary diagnosis
- Anticipated care management needs

Your patients who are members may self-refer to the program by calling 1-800-860-2619. Based on the member-specific information provided, Excellus BlueCross BlueShield will determine which program will best meet the needs of the patient. Once the member has been identified, a care manager contacts the member to disclose specific information about the proposed care management services and ensures the member's willingness to participate. Using standard telephone assessment tools, the care manager assesses the member's needs and determines the acuity and intensity of care management services required.

With the member and physician's participation, the care manager develops an individual Plan of Care that supports the physician's treatment plan. The Plan of Care specifies goals to be met, planned interventions, frequency of follow-up care and discharge criteria.

The Plan of Care is implemented and regularly evaluated for effectiveness towards goal attainment.

The care manager follows Excellus BlueCross BlueShield policy to determine when a member is appropriate for discharge from care management. Discharge criteria are explained to the member throughout the care management process and prior to case closure. The physician is notified at care closure.

Excellus BlueCross BlueShield conducts quality reviews of cases to ascertain, among other criteria, the appropriateness and effectiveness of services provided, the timeliness of follow-up, and staff compliance with care management standards.

4.10.4 24/7 Nurse Call Line

This program is offered for individuals with chronic conditions such as heart disease, asthma, diabetes, back pain, uterine bleeding, prostate cancer, and many others.

The 24/7 Nurse Call Line program supports patients with chronic illnesses in working with their physicians to improve their self-management and make shared decisions. It provides eligible members with 24-hour daily telephone access to nurses and respiratory therapists.. These health coaches provide unbiased, evidence-based health information. The program emphasizes member education, self-management and self-monitoring skills, and support for a member's efforts toward healthy lifestyle changes. The goal is to help patients work with their physicians to improve self-management and decision-making skills. The program also gives patients 24-hour daily on-line access to an encyclopedia of health information.

Program benefits include:

- Free educational packets and self-monitoring tools
- Individual instruction and coaching by telephone through a series of scheduled contacts based on a standard curriculum
- Flexible service hours to meet the member's needs
- Links to available community services
- Encouragement to adhere to the physician's treatment recommendations regarding medication, physical activity, nutrition and self-monitoring

The 24/7 Nurse Call Line toll-free number is 1-800-348-9786.

4.10.5 Additional Case Management Programs

CompassionNet

CompassionNet is a case management program available for children with potentially life-threatening illnesses, and their families. The goal of CompassionNet is to provide supports necessary for the family to continue functioning as normally as possible through a tremendously stressful situation.

Policies

- CompassionNet coordinates the delivery of necessary social and support services with the medical care needed by children diagnosed with potentially life-threatening illness, and their families. CompassionNet does not provide primary care.
- Some of the services that CompassionNet may arrange are:
- Outpatient care
- Home health care
- Referrals to community-based care and support services
- Respite care
- Palliative care consultation
- Equipment/DME/supplies
- Spiritual support
- Counseling to patient and family, including bereavement care
- CompassionNet is open to all Health Plan members who are children.
- Children who have a chronic illness without complications and who are expected to live to adulthood are ineligible for this program.
- CompassionNet, in the discretion of Excellus BlueCross BlueShield, makes available interdisciplinary and complementary services from the time of diagnosis through the course of illness, as needed.
- A CompassionNet case manager may approve concurrent curative and palliative treatments.
- Families may be asked to participate in the cost of optional non-therapeutic services as determined by a sliding scale.

Procedures

To refer an Excellus BlueCross BlueShield member to CompassionNet, the provider treating the child must call CompassionNet. (See the *Contact List* in this manual.)

Case Management for Government Programs Enrollees

Child Health Plus and Medicaid managed care (HMOBlue Option, Blue Choice Option, Premier Option, and HARP) members have access to a dedicated team of care management staff assigned specifically to these government programs.

Case Management

Case management goes beyond traditional case management and provides a holistic approach in identifying psychosocial, medical, behavioral, or functional issues that may impact the members and their enrolled families. The program manages members who have non-complex and complex case management needs. The Case Manager (CM) coordinates and collaborates with internal care management programs, providers, and community resources to ensure member and family needs are met and that they have the ability to overcome barriers to receiving health care services. In addition, all members are provided a 24-hour seven-day per week nursing line to review medical issues and preference-sensitive condition support.

Disease Management

This disease management program provides telephonic outreach, education and support services to those members who are identified as having a chronic condition such as asthma, COPD, diabetes and heart disease to promote member adherence to treatment guidelines. The program spans from early-stage conditions through acute events and severe chronic disease to enhance members' understanding of their condition and encourages positive lifestyle changes to better manage their disease and make informed decisions about their treatment options. The program provides a three-part strategy: first identify individuals with a chronic condition, second, provide targeted information and interventions based on the severity of the illness, and third, work with health care providers to improve chronic conditions. The program includes assistance with medical supplies and community resources to better control the member's condition and avoid complications.

A 24-hour nursing line is available seven days per week to assist members in managing their chronic condition.

Emergency Management

The safety net population has several risk factors that limit the ability to access health care service. In addition, many members lack a physician or transportation, which forces them to seek treatment in an emergency room. Excellus BlueCross BlueShield collaborates with facilities to promote early identification of members seeking ER services. The facilities notify Excellus BlueCross BlueShield by phone or through daily admission reports. This allows the CM to make contact with the member, educate and coordinate discharge orders, and assist the member in overcoming barriers that may affect his or her ability to seek follow-up care.

Pregnancy Prenatal Program

Several major risk factors are associated with poor pregnancy outcomes, including low birth weight and infant mortality (deaths).Some of these risk factors include late or no prenatal care, cigarette smoking, alcohol and other drug use, being HIV positive, spacing of pregnancies, maternal age, poor nutrition and socioeconomic status.

The Prenatal Program emphasizes early identification of pregnant members to improve birth outcomes, care managers assist members in overcoming barriers that impact the frequency of their prenatal care, provide members with relevant pregnancy-related information and link members to available community resources . The program incorporates initiatives to promote and provide incentives for program participation and compliance with prenatal and postpartum care. Prenatal members are screened for depression and other concerns that may relate to poor birth outcomes.

Behavioral Health Program

The safety net Behavioral Health Program provides an integrated, multidisciplinary approach

to managing the member through the health care system. Case Managers specializing in mental health assist members and their families, not only in accessing mental health services, but accessing primary medical and preventive health services. The program coordinates with Behavioral Health Utilization Management to ensure all aspects of the member's care are met. All members are screened for depression. The program promotes and facilitates continuity and coordination of care throughout the member's treatment across the health care continuum to ensure compliance with the treatment plan and medication therapy management.

4.11 Health and Wellness

Workplace Wellness offers self-serve and direct contact programs and services to Excellus BlueCross BlueShield members, to foster early identification of an intervention with preventable conditions, encourage healthy behaviors and improve self-care and informed decision making. Excellus BlueCross BlueShield uses a variety of delivery methods (such as face-to-face, online, telephone and print) to deliver the programs described below.

4.11.1 Risk Reduction Programs

Health Risk Assessment

The Health Risk Assessment (HRA) provides the greatest opportunity to identify individuals at an early stage and engage a member prior to an increase in risk level. An H R A is a questionnaire that asks about lifestyle, diet habits and medical history. Adult members complete this questionnaire on the Internet in less than 15 minutes. The participant receives a *Personal Wellness Report* and a *Chart Summary Report* immediately after completing his/her Health Risk Assessment. The *Wellness Report* recommends actions that a participant can take to protect and improve his/her health. It highlights areas where the participant may already be doing well, and provides ideas for health living and for minimizing risks of being sick or injured in the future. The *Chart Summary Report* can then be printed and used to prompt discussion at the member's next physician visit.

Eligible patients can access the Health Risk Assessment on the Excellus BlueCross BlueShield website.

Health Improvement Programs

Health Plan members have access to comprehensive, web-based programs that can help participants achieve their health objectives in a fun, interactive manner. Members have access to fully personalized programs, in addition to interactive tools and resources to help members meet their health goals. They include:

- Personalized health page with access to daily articles, health tips, and interactive calendars based on personal interests and lifestyle
- Fun interactive tools and trackers

Quit For Life® Program

Quit For Life is a scientifically based telephonic tobacco cessation program established on more than 20 years of published research and clinical experience. When your patients who are eligible Health Plan members enroll in the *Quit For Life* Program they will receive:

- Personalized telephone coaching sessions with a Quit Coach scheduled at their convenience.
- Unlimited toll-free telephone access to a Quit Coach.
- Recommendations on medication type, dose, and duration, where appropriate.
- Free fulfillment of nicotine replacement therapy (such as the patch, or gum).
- A Quit Kit of materials mailed to your patient for help to stay on track between calls.

Excellus BlueCross BlueShield members who are interested in learning more about quitting tobacco can call the Quit For Life Program at the Quit For Life number on the *Contact List* in this manual. If they are not eligible for the program, they will be transferred to the New York State Quitline for assistance.

4.11.2 Decision Support Tools

Healthwise® Knowledgebase

Healthwise Knowledgebase is an online database containing evidence-based content on over 6,000 topics. The database provides insight on questions regarding health conditions, medical tests, procedures, medications and everyday health and wellness. Healthwise has a "decision point" feature that helps individuals understand their options and provides information to help them make wise decisions. There are seven opportunities to use Healthwise including:

- Self-care
- Self-triage
- Provider visit preparation
- Self-management of chronic conditions
- Shared decision making
- End-of-life care

The Healthwise Knowledgebase is available to **all** BlueCross BlueShield members from the Excellus BlueCross BlueShield website. From the Member page, select *For Your Health* in the top bar menu, then click on *6,000+ Health Topics* in the Quick Links menu on the left.

Cost Estimator Tool

- Managing the quality and cost of members' health care is important. Excellus BlueCross BlueShield's online treatment cost estimator makes it easy. Members get easy-to-understand estimates based on their current benefit plan and cost-sharing amounts: Search from a wide variety of treatments, Including inpatient services, outpatient services, diagnostics, and office visits
- Estimate treatment costs
- Find out-of-pocket costs
- Sort provider results by cost, distance, and number of treatments

To get to Cost Estimator Tool from the Member page, select *For Your Health* in the top bar menu, then click on *Estimate Treatment Costs* in the Decision Support Tools box on the right side of the web page, then on *Get started now*. At this point, the member must register and log in.

4.11.3 Worksite Wellness

Excellus BlueCross BlueShield's Worksite Wellness Services are designed to enhance the care coordination approach while motivating members to become more knowledgeable health care consumers. Services are coordinated through employers and accessed by members at their worksites. Services include:

Preventive Health Screenings

All health screening participants receive lifestyle counseling that includes feedback about their results and what, if any, actions they need to take. Members with abnormal results are sent a letter reminding them to follow-up with their primary care physicians. Members also receive educational materials and are connected to Excellus BlueCross BlueShield's health and medical programs and services.

The following screenings can be provided:

- Blood pressure
- Blood glucose
- Body mass index (BMI)
- Total cholesterol
- Lipid profile

Health Education Programs

More than 15 education programs are offered covering a wide selection of topics to promote healthier lifestyles. These topics are offered in a one-hour format.

Wellness Videos

Excellus BlueCross BlueShield provides video presentations on a variety of health topics, such as stress management and nutrition. The videos are short, web-based health seminars that provide health information available at no additional cost. These wellness videos are available on Excellus BlueCross BlueShield's YouTube channel.

Blue4U

Blue4U is a powerful, metrics-based health awareness and preventive care program that helps eligible members get engaged in their own well-being. Powered by Interactive Health, the nation's premier population health management company, eligible members participate in voluntary biometric screenings that generate data about health metrics such as cholesterol, glucose, triglycerides, blood pressure and tobacco use.

The Blue4U program utilizes a group's existing benefit design from Excellus BlueCross BlueShield to provide preventive services to eligible members. Claims are billed directly to Excellus BlueCross BlueShield for members (both eligible spouses and domestic partners).

Blue4U has multiple impacts on business performance, helps reduce the cost of medical benefits and increases workforce productivity. Blue4U helps identify potential conditions and provides tools for participants to manage these risks and work towards a low-risk health state.

4.11.4 Member Discounts— Blue365

Excellus BlueCross BlueShield has established discounts for products and services that support healthy lifestyles. Members have access to substantial discounts, savings and unique experience-based packages. Excellus BlueCross BlueShield discounts are called Blue365 and are available to all members regardless of the subscriber's health benefit.

Members can view our discounts and programs online at Excellus BlueCross BlueShield's website.

4.12 Utilization Review Appeals and Grievances

Note: The following procedures do not apply to Medicare Advantage programs or Medicaid managed care programs. For appeals and grievance procedures available to members of Medicare Advantage health benefit programs, see the *Medicare Advantage* section of this manual. For appeal and grievance procedures available to members of Medicaid managed care programs, see the *Government Programs* section of this manual.

The following paragraphs describe:

- The handling of appeals that involve a medical necessity determination (see paragraphs headed *Internal Appeals* and *External Appeals*).
- The review of issues (including quality of care and access to care complaints) not associated with medical necessity or experimental and/or investigational determinations, excluding service requests (see paragraphs headed *First-level Grievance* and *Second-level Grievance*).

This process is intended to provide a reasonable opportunity for a full and fair review of an adverse determination.

4.12.1 General Policies

- **Assistance of a designee.** A member may designate a representative (including a lawyer or health care provider) to act on his or her behalf at any stage of the appeal or grievance process. The designation must be in writing. For the purpose of this

policy, any reference to member includes a member's designated representative if the member has chosen one

- **Internal Appeal**. If a member is not satisfied with a medical necessity determination or an experimental and/or investigational determination of Excellus BlueCross BlueShield, the member may submit an internal appeal. All requirements pertaining to internal appeals are described below
- **Expedited Internal Appeal.** Cases involving the following are subject to an expedited internal appeal:
    - Requests for review of continued or extended health care services;
    - Requests for additional services in a course of continued treatment; or
    - Cases (other than retrospective review cases) in which a provider requests an immediate review
- **External Appeal.** If a member is not satisfied with an internal appeal determination (the "final adverse determination" for purposes of external appeal), an insured member may submit a request to the New York State Insurance Department for an external appeal. For members in a self-insured plan, external appeals *may* be available as required by the Patient Protection and Affordable Care Act. All requirements pertaining to external appeal are described below
- **Level One Grievance.** If a member is not satisfied with a determination made by or on behalf of Excellus BlueCross BlueShield that does not involve a medical necessity determination or an experimental and/or investigational determination, the member may submit a Level One grievance. All requirements pertaining to Level One grievance review are described below
- **Level Two Grievance.** If a member is not satisfied with a Level One grievance determination, the member may submit a Level Two grievance. All requirements pertaining to Level Two grievance reviews are described below
- **No Retaliation.** Excellus BlueCross BlueShield will not retaliate or take any discriminatory action against a member because the member requested an internal or external appeal
- **Legal Action.** The levels of appeal/grievance below should be exhausted before a member can bring legal action against Excellus BlueCross BlueShield
- **Automatic Reversal.** For insured members, Excellus BlueCross BlueShield's failure to render a determination on a *standard appeal* within 60 calendar days from receipt of all necessary information results in a reversal of the initial adverse determination. Failure to render a determination on an *expedited appeal* within two business days from receipt of all information will result in a reversal of the initial adverse determination

4.12.2 The Appeal Process

Policies

Members have the right to request the identification of all experts whose advice Excellus BlueCross BlueShield obtained in connection with an adverse determination. In addition, if Excellus BlueCross BlueShield upholds a claim denial on appeal, members have the right to request, free of charge, copies of all documents and other information relevant to Excellus BlueCross BlueShield's claim determination. All appeals are thoroughly documented and investigated.

Procedure

1. The member and, in post-service (retrospective) review cases, the member's health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing.
   a. The member may make a verbal request by calling the phone number listed on his/her identification card. Written appeal requests can be submitted to the address of Excellus BlueCross BlueShield listed on the member's identification card
   b. The member has up to 180 calendar days from receipt of the notice of adverse determination to file an appeal
   c. The member, the member's health care provider or the member's designated representative has the right to submit written comments, documents or other information in support of the appeal
2. Excellus BlueCross BlueShield will acknowledge the request for an appeal within 15 calendar days of receipt of the appeal. The acknowledgment will include the name, address and phone number of the person handling the appeal. If necessary, it will inform the member—and in post-service (retrospective) review cases, the member's health care provider—of any additional information needed before a decision can be made
3. In cases where additional information is deemed necessary, the following guidelines will apply

- ***Standard Appeals***

  Excellus BlueCross BlueShield will send a letter to the member and his/her provider requesting and identifying the additional information needed. Excellus BlueCross BlueShield will send this letter within the applicable case time period but no later than 15 calendar days of receipt of the request for appeal.

  If, subsequently, the member and/or his/her provider provide only partial information to Excellus BlueCross BlueShield, Excellus BlueCross BlueShield will send a letter *to the member and his/her provider* requesting and identifying the additional information needed. Excellus BlueCross BlueShield will send this letter within five business days of receipt of the partial information.

- ***Expedited Appeals***

Excellus BlueCross BlueShield will expeditiously request and specify the additional information via phone or fax from the member and his/her provider followed by written notification to the member and provider.

- When Excellus BlueCross BlueShield reviews a claim on appeal, it will not give any deference to the initial decision clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial decision.

  Note: A clinical peer reviewer is defined as a physician who possesses a current and valid non-restricted license to practice medicine or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition or provides the treatment at issue.

4.12.3 Medical Necessity or Experimental/Investigational Appeals

Expedited Appeals

Excellus BlueCross BlueShield will decide appeals involving pre-service (prospective) events within the lesser of two business days or 72 hours of receipt of the appeal. Written notice will follow within 24 hours of Excellus BlueCross BlueShield's determination, but no later than 72 hours of receipt of the appeal request. Excellus BlueCross BlueShield will provide reasonable access to its Clinical Peer Reviewer within one business day of receiving notice of taking the expedited appeal. If the member is not satisfied with the resolution of the expedited appeal, he/she may file a standard internal appeal or an external appeal.

Excellus BlueCross BlueShield will transmit all information relating to the appeal to the member and the member's provider, and will accept by telephone or facsimile information from the member, the member's provider or the member's designated representative relating to the appeal.

Excellus BlueCross BlueShield will handle reviews of continued or extended health care services and additional services rendered in the course of continued treatment as expedited appeals.

Pre-Service Appeals

Excellus BlueCross BlueShield will decide appeals involving pre-service (prospective) matters within 30 calendar days of receipt of the appeal request. Excellus BlueCross BlueShield will provide written notice of the determination to the member (and the member's provider if he or she requested the review) within two business days after the determination is made, but not later than 30 calendar days after receipt of the appeal request.

Post-Service Appeals

Excellus BlueCross BlueShield will decide appeals filed post-service (retrospective) within 60 calendar days of receipt of the appeal request. Excellus BlueCross BlueShield will provide written notice of the determination to the member (and the member's provider if he or she requested the review) within two business days after the determination is made, but not later than 60 calendar days after receipt of the appeal request.

Determination Upon Appeal

Upon making its determination, Excellus BlueCross BlueShield will send a notice of determination of the internal appeal that will include the following information:

- A clear statement describing the basis and clinical rationale for the denial as applicable to the member
- The titles and credentials of the appeal reviewer
- A clear statement that the notice constitutes a final adverse determination
- Excellus BlueCross BlueShield's contact person and his or her telephone number;
- The member's coverage type
- The name and full address of Excellus BlueCross BlueShield's utilization review agent (which may be Excellus BlueCross BlueShield itself)
- The utilization review agent's contact person and his or her telephone number
- A description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or provider proposed to provide the treatment and the developer/manufacturer of the health care service
- A statement that the member may be eligible for an external appeal and the time frames for requesting an appeal (a copy of an external appeal application is sent to the member with the final adverse determination letter); and
- A clear statement written in bolded text that the 45-day time frame (effective July 1, 2014, the time frame for provider-initiated external appeals is 60 days) or four months for member-initiated external appeals (whichever is applicable) begins upon receipt of the final adverse determination of the first level appeal, regardless whether a second level appeal is requested; and that by choosing to request a second level internal appeal, the time may expire for the enrollee to request an external appeal

Excellus BlueCross BlueShield will keep all requests and discussions confidential and no discriminatory action will be taken because the member has filed an appeal. There is a process for both standard and expedited appeals. Appeals are thoroughly reviewed and documented. Excellus BlueCross BlueShield will maintain a file on each appeal that includes the date the appeal was filed; a copy of the appeal, if written; the date upon which the acknowledgment was received, and a copy of the acknowledgment; the appeal determination, including the date of the determination; and the titles of the personnel and credentials of clinical personnel who reviewed the appeal.

4.12.4 External Appeals

A provider can request an external appeal for concurrent and post-service (retrospective) adverse determinations, only. A provider may **not** request an external appeal pre-service utilization review determination. A provider must use a separate request form (available upon request from Excellus BlueCross BlueShield) to request external appeal. Upon the provider's request, Excellus BlueCross BlueShield will send him/her the request form within three business days. For out-of-network denials, an external appeal may be available if the member's attending physician (who must be board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease) submits a statement to Excellus BlueCross BlueShield that the service is materially different that the service approved by Excellus BlueCross BlueShield. The member's physician must also submit two documents from the available medical and scientific evidence that the service is likely to be more clinically beneficial and for which the adverse risk of the requested service would not likely be substantially increased over treatment covered by Excellus BlueCross BlueShield.

An external appeal may also be filed:

1. When the member has had coverage of a health care service denied on the basis that such service is experimental or investigational, **and**
2. the denial has been upheld on appeal **or** both Excellus BlueCross BlueShield and the member have jointly agreed to waive any internal appeal
3. **and** the member's attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health care services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by Excellus BlueCross BlueShield or (c) for which there exists a clinical trial
4. **and** the member's attending physician, who must be a licenses, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must have recommended either (a) a health service or procedure that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. The physician certification mentioned above will include a statement of the evidence relied upon by the physician in certifying his/her recommendation,
5. **and** the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.
6. **Or,** the appeal is related to continued inpatient treatment for substance use

For self-insured members, under the Patient Protection and Affordable Care Act (PPACA), external appeals are available for denials related to medical necessity, experimental/investigational or any contractual issue. A self-insured group must NOT be grandfathered from PPACA rules for the external appeal option to apply.

Procedure

1. A provider or a member may submit a request for an external appeal:

   a. For insured members, the provider, effective 7/1/14, has 60 days from the time the provider receives the notice of the final adverse determination to submit the external appeal. For eligible self-insured members, the provider has four months from the time the provider receives the notice of the final adverse determination to submit the external appeal

      In the event that the enrollee (member) has pursued the internal appeal process without notifying the provider, it is possible that the provider would never have received "notice" of the final adverse determination. Under such circumstances, an enrollee whose 60-day /four-month deadline had expired could revive his/her time for filing simply by "notifying" the provider of the final adverse determination and asking the provider to request the external appeal on the enrollee's behalf. To protect against this, the member may file an application as explained in *b,* below

   b. A member may file an application for an external appeal by an approved external appeal agent if the member has received a denial of coverage based on medical necessity or because the service is experimental and/or investigational. To be eligible for an external appeal, the member must have received a final adverse determination as a result of Excellus BlueCross BlueShield's internal appeal process, or Excellus BlueCross BlueShield and the member must have agreed jointly to waive the internal utilization review appeal process, **or** the appeal is related to continued inpatient treatment for substance use

2. The member or provider may obtain an external appeal application:
   - For insured members, from the New York State Department of Financial Services at 1- 800 -400-8882, or its website dfs.ny.gov
     OR
   - By calling Excellus BlueCross BlueShield at the telephone number listed on the member's Health Plan identification card
     - The application will provide clear instructions for completion. A fee of $50.00 may be required to request an external appeal. Excellus BlueCross BlueShield waives the cost to the member for filing an external appeal.
   - For insured members, the application, made by the provider, for external appeal must be made within 60 days, effective July 1, 2014, of the member or provider's receipt of the notice of final adverse determination as a result of Excellus BlueCross BlueShield's appeal process, or within 60 days of when Excellus BlueCross BlueShield and the member and/or provider jointly agreed to waive the internal appeal process. For eligible self-insured members, the application for external appeal must be made within four months of the member or provider's receipt of the notice of final adverse determination as a result of Excellus BlueCross BlueShield's appeal process, or within four months of when Excellus BlueCross BlueShield and the member and/or provider jointly agreed to waive the external appeal process.

The member may request an expedited external appeal if the member and/or the member's health care provider can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to the member's health.
A member will lose his/her right to an external appeal if he/she does not file an application for an external appeal within four months from receipt of the final adverse determination from the internal appeal.

3. The application will instruct the member where to send the external appeal. The member must release all pertinent medical information concerning his/her medical condition and request for services.
4. An independent external appeal agent approved by the State will review the request to determine if the denied service is medically necessary and should be covered by Excellus BlueCross BlueShield. All external appeals are conducted by clinical peer reviewers. The agent's decision is final and binding on both the member and Excellus BlueCross BlueShield.

For standard appeals, the external appeal agent must make a decision within 30 days of receiving the application for external appeal. Five additional business days may be added if the agent needs additional information.

If the agent determines that the information submitted is materially different from that considered by Excellus BlueCross BlueShield, Excellus BlueCross BlueShield will have three additional business days to reconsider or affirm its decision. The member will be notified within two business days of the agent's decision.

Expedited appeals will be decided within the lesser of seventy-two hours of receipt of the appeal or within two business days of receipt of the information necessary to conduct the appeal. The agent will make every reasonable effort to notify the member and Excellus BlueCross BlueShield of the decision immediately by phone or fax. This will be followed immediately by a written notice.

4.12.5 Appeals Based on any Reason other than Medical Necessity or Experimental/Investigational Denials (Grievances)

If a member is not satisfied with a determination made by or on behalf of Excellus BlueCross BlueShield that does not involve a medical necessity determination or an experimental and/or investigational determination, the member may submit a grievance.

For example, the grievance procedure would be used to resolve a dispute in which Excellus BlueCross BlueShield decided that the member does not meet the requirements for coverage of a particular service, or that an out-of-area referral was unnecessary. The grievance procedure also applies to complaints involving service quality.

Filing a First-Level Grievance

1. The member or his/her designee may file a first-level grievance either by phone, in person or in writing.

- The member may make a verbal request by calling the phone number listed on his/her identification card. Written grievance requests can be submitted to the address of Excellus BlueCross BlueShield listed on the member's identification card.
- The member has up to 180 calendar days from receipt of the decision to file a grievance.
- Excellus BlueCross BlueShield will acknowledge the request for a grievance within 15 calendar days of its receipt. The acknowledgment will include the name, address and phone number of the person handling the grievance. If necessary, the acknowledgment will inform the member of any additional information needed before a decision can be made. The member may submit additional information pertinent to the grievance.

2. When Excellus BlueCross BlueShield reviews a first-level grievance, it will not give any deference to the initial decision. When a member files a first-level grievance, an individual who is not subordinate to the individual who rendered the initial determination will review the grievance. If the first-level grievance involves a clinical matter, a clinical peer reviewer will decide the first-level grievance.

   Excellus BlueCross BlueShield will keep all requests and discussions confidential and no discriminatory action will be taken because the member has filed a grievance. There is a process for both standard and urgent grievances. Grievances are thoroughly reviewed and documented. Excellus BlueCross BlueShield will maintain a file on each grievance. The file will include the date the grievance was filed; a copy of the grievance, if written; the date of receipt of and a copy of the acknowledgment; the grievance determination, including the date of the determination; and the titles of the personnel and credentials of clinical personnel who reviewed the grievance.

3. Excellus BlueCross BlueShield will make its determination.

   a. Urgent Grievances

   If a first-level grievance relates to an urgent matter, Excellus BlueCross BlueShield will decide the first-level grievance and notify the member of the determination by phone within 48 hours of receipt of the first-level grievance request. Written notice will follow within 24 hours of Excellus BlueCross BlueShield's determination.

   b. Pre-Service Grievances

   If a first-level grievance relates to a pre-service (prospective) matter, Excellus BlueCross BlueShield will decide the first-level grievance and notify the member of the determination in writing within 15 calendar days of receipt of the first-level grievance request.

   c. Post-Service Grievances

   If a first-level grievance relates to a post-service (retrospective) matter, Excellus BlueCross BlueShield will decide the first-level grievance and notify the member of the determination in writing within 30 calendar days of receipt of the first-level grievance request.

d. Intangible Level 1 Grievances

Intangible grievances include the following categories:

- *Clinical Quality of Care*. A clinical quality concern is one that may adversely affect the health and/or well-being of the member. Examples of this may include perceptions of inadequate or inappropriate treatment or failure to diagnose accurately
- *Access to Care.* Inability to obtain a timely appointment or after-hours appointment.
- *Interpersonal Issues.* Interpersonal issues with a provider or his/her office staff or other complaints against the corporation

All intangibles must be resolved and the member notified within 45 calendar days after receipt of all information. Excellus BlueCross BlueShield will handle urgent clinical situations expeditiously. Excellus BlueCross BlueShield will notify the member of the results of an expedited review within 72 hours after receipt of all information.

4. Upon making its determination, Excellus BlueCross BlueShield will send a notice of determination of the first-level grievance that will include:

    - The name and title of the reviewer
    - Detailed reasons for the determination, and, if the grievance involves a clinical matter
    - The clinical rationale for the determination, if the determination has a clinical basis, and information about how to file a second-level grievance, including the appropriate form, if applicable

Filing a Second-level Grievance

1. If a member is not satisfied with the resolution of a first-level grievance, the member or his/her designated representative may file a second-level grievance.
    - A member has up to 180 calendar days from receipt of the first-level grievance determination to file a second-level grievance
    - The member may file a second-level grievance by phone, in person or by writing
2. Excellus BlueCross BlueShield will acknowledge the request for a second-level grievance within 15 calendar days of receipt. The acknowledgment will include the name, address and phone number of the person handling the grievance.
    - Excellus BlueCross BlueShield will review the second-level grievance. One or more qualified personnel at a higher level than the personnel who rendered the first-level grievance determination will decide the second-level grievance. If the second-level grievance involves a clinical matter, a clinical peer reviewer will decide the second-level grievance
3. Excellus BlueCross BlueShield will make its determination.

a. Urgent Grievances

If the second-level grievance relates to an urgent matter, Excellus BlueCross BlueShield will decide the second-level grievance and notify the member of the determination by phone within 24 hours of receipt of the second-level grievance request. Written notice will follow within 24 hours of Excellus BlueCross BlueShield's determination.

b. Pre-Service Grievances

If a second-level grievance relates to a pre-service matter, Excellus BlueCross BlueShield will decide the second-level grievance and notify the member of the determination in writing within 15 calendar days of receipt of the second-level grievance request.

c. Post-Service Grievances

If a second-level grievance relates to a post-service matter, Excellus BlueCross BlueShield will decide the second-level grievance and notify the member of the determination in writing within 30 calendar days of receipt of the second-level grievance request.

d. Intangible Level 2 Grievances

Intangible grievances include the following categories:

- *Clinical Quality of Care*. A clinical quality concern is one that may adversely affect the health and/or well-being of the member. Examples of this may include perceptions of inadequate or inappropriate treatment or failure to diagnose accurately
- *Access to Care.* Inability to obtain a timely appointment or an after-hours appointment availability
- *Interpersonal Issues*. Interpersonal issues with a provider or his/her office staff or other complaints against the corporation

All intangibles must be resolved and the member notified within 45 calendar days after receipt of all information. Excellus BlueCross BlueShield will handle urgent clinical situations expeditiously. Excellus BlueCross BlueShield will notify the member of the results of the expedited review within 72 hours after receipt of all information.

4. Upon making its determination, Excellus BlueCross BlueShield will send a notice of determination of the second-level grievance that will include:
    - The name and title of the reviewer
    - Detailed reasons for the determination, and
    - If the grievance involves a clinical matter, the clinical rationale for the determination

5. If an insured member remains dissatisfied with a first-level and/or second-level grievance determinations, or if he/she is dissatisfied at any other time, the member may:
   - Contact the New York State Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237, 1-800-206-8125, for managed care products,

     and/or
   - Contact the New York State Department of Financial Services, Consumer Services Bureau, One Commerce Plaza, Albany, New York 12257, 1-800-342-3736

Excellus BlueCross BlueShield Participating Provider Manual

5.0 Pharmacy Management

This section includes information about prescription drug benefits as well as information about drugs that are covered as a medical benefit (such as certain injectable and infusion drugs that are administered by a health care practitioner).

5.1 Pharmacy Benefits

Excellus BlueCross BlueShield is committed to effectively managing prescription drug benefit costs and providing members with affordable access to prescription drugs. Pharmacy benefits for many of our members are administered by Excellus BlueCross BlueShield. Providers should direct pharmacy benefit authorizations or inquiries to the Pharmacy Help Desk. The Pharmacy Help Desk telephone numbers and address are listed on the *Contact List* in this manual.

> **Note:** Prescription drug benefits are added to many health benefit programs by way of a rider. Not all health benefit programs include a prescription drug benefit. Member ID cards for programs that include drug benefits include an "Rx" symbol.

5.2 Medication Guides

Excellus BlueCross BlueShield makes available to members, providers, employers and guests a three-tier formulary guide as well as a closed formulary guide. Both list generic and brand-name medications. The Pharmacy and Therapeutics Committee, composed of practicing community physicians and clinical pharmacists, defines the drugs in each category. The committee meets regularly to review the drugs on the formularies.

The three-tier, closed and Health Plan Marketplace (metal level) formularies can be viewed on Excellus BlueCross BlueShield's website, ExcellusBCBS.com/ProviderPrescriptions and select *Check Our Drug List*. Provider offices that do not access the Internet may request paper copies from the Pharmacy Help Desk. (See the *Contact List* in this manual.)

5.2.1 Three-Tier Drug Plan

This drug benefit design provides three tiers of coverage with a graduating scale of patient copayment/coinsurance based on the tier assignment of the prescribed drug. Members play a vital role in controlling the rising cost of prescription drugs, and this three-tier benefit gives them the incentive to make informed decisions about the medications they take.

The three tiers are categorized as:

- **Tier One-** Typically, generic drugs. Generic drugs have the same active ingredients, strength and effectiveness as their brand-name counterparts but at a substantially lower cost. There may be instances where brand-name drugs may be placed in Tier One for clinical reasons.
- **Tier Two-** Typically, brand-name products selected because of their overall value. There may be instances where generic drugs may be placed in Tier Two for clinical reasons.
- **Tier Three-** All other prescription drugs. This includes FDA-approved drugs that are pending placement by Excellus BlueCross BlueShield's Pharmacy and Therapeutics Committee. There may be instances where generic drugs may be placed in Tier Three for clinical reasons.

The three-tier prescription benefit focuses on cost-sharing. Members using Tier Three drugs will be responsible for the highest out-of-pocket expenses.

5.2.2 Two-Tier Closed Formularies for Child Health Plus and Medicaid Managed Care Products

The Child Health Plus prescription drug benefit is managed by Excellus BlueCross BlueShield. It is based on a two-tier closed formulary. The Child Health Plus formulary is available on our website at ExcellusBCBS.com/ProviderPrescriptions, or you may call the Pharmacy Help Desk to request a copy. The Child Health Plus benefit allows coverage for Medicaid-approved over-the-counter drugs.

The prescription drug benefits for our Medicaid managed care products _ HMOBlue Option, Blue Choice Option, Blue Option Plus and Premier Option Plus are also managed by Excellus BlueCross BlueShield, and are available on our website at ExcellusBCBS.com/ProviderPrescriptions, or you may call the Pharmacy Help Desk to request a copy. The Medicaid managed care benefit allows coverage for Medicaid-approved over-the counter drugs.

5.3 Online Edits

The online drug claims processing system provides safety and accuracy checks. As a prescription is filled, the system checks it against a series of safety and quality criteria, including:

- **Quantity Limits**. Limits apply based on standard FDA-approved dosing and established, clinically appropriate dosing parameters.
- **Drug Utilization Review (DUR) Messaging.** Messages assure member safety by providing information about possible drug interactions, duplications and dosing errors.

5.4 Prior Authorization

Some drugs require prior authorization before Excellus BlueCross BlueShield will pay for the medication. Excellus BlueCross BlueShield has developed a list of medications requiring Prior Authorization or Step Therapy. The list is subject to change. The most current version is available at ExcellusBCBS.com/ProviderPrescriptions.

> **Note:** For Medicaid managed care members, except as otherwise prohibited by law, Excellus BlueCross BlueShield allows immediate access without prior authorization to a seventy-two (72) hour emergency supply of a prescribed drug or medication for an individual with an emergency medical or behavioral condition as defined in the individual's contract. In addition, Excellus BlueCross BlueShield will immediately authorize a seven-day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization.

5.4.1 Prescription Drugs Requiring Prior Authorization

Excellus BlueCross BlueShield has available a drug-specific prior authorization form for each drug or drug category. For those drugs requiring prior authorization, prescribing practitioners can complete and submit the appropriate prior authorization form. (Drugs that require prior authorization are also indicated on the formulary.)

The most current version of each form is available from Excellus BlueCross BlueShield's website, ExcellusBCBS.com/ProviderPrescriptions.

Select *Prescriptions > Prior Authorization & Step Therapy >All Other Drugs and Specialty Medications – All Excellus Health Plan Members.* Practitioners may also call the Pharmacy Help Desk to request the appropriate form. We will fax or mail the form directly to the requestor. (Telephone numbers and addresses are listed on the *Contact List* in this manual.)

Prescribing practitioners must complete all required fields on the prior authorization forms, including the member's ID number, located on the front of the member ID card. We will return incomplete forms for correction before a review determination can be made. All prior authorization forms must be signed by the requesting provider before review can take place.

Practitioners should fax prior authorization requests and step therapy exceptions to the Health Plan. (The fax number is included on each form.) Responses will be faxed to the practitioner's office.

Offices without access to a fax machine may call or write to the Pharmacy Help Desk to request prior authorization approval. To expedite the process, providers should have all required information available prior to placing the call.

5.4.2 Step Therapy Program

The Step Therapy Program promotes the use of clinically sound generics and cost-effective therapeutic alternatives in select therapeutic classes. The program provides recommendations for prescribing first-line medications. The program applies to members with prescription drug benefits that include prior authorization requirements.

As part of the program, we require step therapyfor certain drugs within select categories. The Step Therapy Program can apply to new starts or existing users of the targeted medication.. For example, a patient who is prescribed Actonel® for the first time and has had a trial of alendronate in pharmacy claims history in the past 365 days will NOT require prior authorization.

For the most current list of step therapy prescribing recommendations, refer to Excellus BlueCross BlueShield's website, ExcellusBCBS.com/ProviderPrescriptions and select *Prior Authorization & Step Therapy >Prescriptions Requiring Prior Authorization or Step Therapy,* or contact the Pharmacy Help Desk.

5.4.3 Exception Process

Excellus BlueCross BlueShield has an exception process in place. To request an exception to the formulary, prior authorization, step therapy and other use management programs, the prescribing physician must complete a request form and fax it to the Pharmacy Help Desk at the number listed at the bottom of the form. The prescribing physician may use the *General Exception Request Form* available on Excellus BlueCross BlueShield's website or, if available, a form specific to the drug for which the exception is requested. See the sections above regarding prescription drugs requiring prior authorization for instructions to access the necessary form(s).

5.5 Specialty Medication Pharmacy Network

Specialty medications, such as those for the treatment of diseases like multiple sclerosis, hepatitis C and rheumatoid arthritis that are covered under the prescription drug benefit (self-administered medications), can be ordered from our specialty pharmacy network. Participating national vendors Accredo Health Specialty Pharmacy and Walgreens Specialty Pharmacy will supply and ship all self-injected medications covered under the pharmacy benefit directly to the patient.

Certain prescription drug benefits require that select specialty medications be purchased from our participating network specialty pharmacy to receive coverage under the prescription drug benefit. Information about national and local vendors and the medications affected is available from Excellus BlueCross BlueShield's website, ExcellusBCBS.com/ProviderPrescriptions. Select *Find a Pharmacy > Find a Specialty Pharmacy.* The website also includes a list of specialty medications, as well as links to the specialty pharmacy vendors.

The telephone numbers for Accredo Health Specialty Pharmacy and Walgreens Specialty Pharmacy are included on the *Contact List* in this manual. There are also several local

pharmacies that participate in the specialty network. Providers (or members) may call the Pharmacy Help Desk to learn whether there are any in a specific area.

Specialty Pharmacy is an Option for Obtaining Medical Drugs

Excellus BlueCross BlueShield offers providers the option of using specialty pharmacies to obtain drugs that they prefer not to stock in the office. Excellus BlueCross BlueShield's contracted specialty pharmacies will ship the drug to the provider's office and bill Excellus BlueCross BlueShield directly.

Most medical drugs and medical specialty drugs may be obtained either through a contracted specialty pharmacy or purchased directly by a physician and billed to Excellus BlueCross BlueShield. Please note that you do not bill Excellus BlueCross BlueShield for the drug when using a specialty pharmacy.

Specialty Pharmacies—What is the process?

1. **The drug you wish to prescribe requires preauthorization.**
   - Complete the appropriate prescription form.
   - Complete the preauthorization form.
   - Fax the completed prior authorization form to the medical specialty unit listed on the form. Fax numbers for specialty pharmacies are listed at the top of the preauthorization form.
2. **The drug you wish to prescribe does NOT require preauthorization.**
   - Complete the appropriate prescription form.
   - In addition to the prescription, please include member-specific insurance and demographic information.
   - Electronically send or fax the prescription with the additional information above to the specialty pharmacy. (See specialty pharmacy fax numbers on the *Contact List* in this manual.)

5.6 Medical and Medical Specialty Drugs F

Medical drugs are defined as those drugs that are administered by a health care provider in the office, at an infusion center, at an outpatient facility or by nurses in home care. Medical drugs are covered under a member's medical benefit. *(Prescription drugs are defined as those drugs that can be self-administered and are covered under a member's prescription drug benefit.)*

Some medical drugs may also fall into the category of medical specialty drugs due to limited distribution or other unique characteristics. These may require preauthorization.

Please refer to Excellus BlueCross BlueShield's website for additional information, including a list of provider-administered drugs that require preauthorization, preauthorization forms, information about contracted specialty pharmacies, and specific medical drug policies.

Providers may also contact the Medical Specialty Medication Review unit directly for forms and information. (See the *Contact List* in this manual.)

> **Note:** Claims will deny or suspend for review across all lines of business for provider-administered medications that require preauthorization, unless preauthorization has been obtained.

To access the list, go to ExcellusBCBS.com/ProviderPrescriptions and select *Prior Authorization & Step Therapy > Provider Administered Drugs Requiring Preauthorization*. Additional information is available at *Prescriptions > Prescription Drug Policies*.

Preauthorization is handled through the **Medical Specialty Medication Review Program,** a centralized unit that performs medical necessity reviews for medications covered under the medical benefit that require preauthorization. The Medical Specialty Medication Review Program unit is staffed with clinical pharmacists, physicians, and nurses. Providers may obtain medical drug preauthorizations and forms from Excellus BlueCross BlueShield website, or contact the Medical Specialty Medication Review Unit directly for more information. (See the *Contact List* in this manual.)

5.7 Generic Advantage Program

Excellus BlueCross BlueShield's prescription drug benefit is designed to encourage value when selecting prescription drugs. The Generic Advantage Program for maximum allowable cost is part of that drug benefit. This program applies to a list of brand-name drugs that have Food and Drug Administration (FDA) approved generic alternatives. Members of Medicaid managed care and Child Health Plus are **not** eligible to participate in this program.

With the Generic Advantage Program, if a member purchases a brand-name medication when there is a generic equivalent available, he/she will pay:

- the generic copayment/coinsurance amount; and
- the difference between Excellus BlueCross BlueShield's network discount price for the more costly brand-name medication and Excellus BlueCross BlueShield price for the less expensive generic.

5.8 Mandatory Mail-Order for Maintenance Drugs

Some prescription drug benefits require select medications be purchased through the mail-service pharmacy for coverage. The most current list of medications that must be purchased through mail- service is available on Excellus BlueCross BlueShield's website under *Find a Pharmacy*. Scroll down and click on *List of Medications Required to be Purchased through Mail Service*. Providers who do not access the Internet from the office may request a copy from the Pharmacy Help Desk.

5.9 Medicare Part D Prescription Drug Benefit

Excellus BlueCross BlueShield offers the Medicare Part D prescription drug benefit for many of its Medicare Advantage (MA) products. The Medicare Part D Prescription Drug benefit was designed for the unique medication needs of Medicare beneficiaries.

Formulary

The Centers for Medicare & Medicaid Services (CMS) established requirements for the drugs covered under Part D. The Medicare Part D formulary focuses on drug categories and medications used in the Medicare population. It has a strong emphasis on the use of generics and cost-effective choices for key conditions. The Medicare Part D formulary, as well as other program information, is available on Excellus BlueCross BlueShield's website. Changes to the Medicare D formulary are posted to our website 60 days prior to the implementation.

5.10 Other Web-Based Pharmacy Services

Both members and providers can access the following pharmacy services through Excellus BlueCross BlueShield's website, ExcellusBCBS.com.

Pharmacy Locator

The Excellus BlueCross BlueShield website also provides:

- Search capability for more than 63,000 nationwide pharmacies that participate in the pharmacy network. There are also selected pharmacies that participate in our Medicare Part D network.
- Information about the mail service pharmacy network available to members who have prescription drug coverage.
- Information about the Specialty Rx Care Program that helps manage the high costs of biotech medications by using specialty pharmacies that focus on monitoring and distributing these new, high-cost medicines.

Drug Information Via eMail

The clinical pharmacists of Pharmacy Management are available to answer questions on a broad range of topics, including new clinical data, adverse drug reactions, optimal drug selection, therapeutic uses, drug interactions and monitoring parameters, drugs in the news and a generic drug options chart. Visit ExcellusBCBS.com/ProviderAskPharmacist to send an email message.

We make every effort to answer questions as soon as possible. However, please allow three business days for a response.

Excellus BlueCross BlueShield Participating Provider Manual

6.0 Behavioral Health

6.1 Program Administration

6.1.1 Behavioral Health Department

The Behavioral Health (BH) department maintains, monitors, and evaluates BH care and services for clinical effectiveness and efficiencies, aligning with the corporate mission and goals. Services are assessed for appropriate, medically necessary, effective levels of care, supportive resources, and progressive interventions for improvement to ensure high quality care and patient safety. Treatment services are reviewed in accordance with nationally recognized criteria, McKesson, Behavioral Health InterQual® Level of Care Criteria, corporate medical policies and New York state policies for mental health to determine medical necessity.

For substance use services delivered to our Commercial, Medicare, Child Health Plus and Medicaid managed care members, Excellus BlueCross BlueShield uses its corporate medical policies and the New York state LOCADTR tool to determine medical necessity.

6.1.2 Behavioral Health Department Integration

The BH department, in partnership with its BH organization delegate, reviews proposals and collaborates with ad hoc workgroups for input into BH clinical services programs and activities, care management program enhancements, service quality, continuity and coordination of care program activities, and practitioner utilization trends. The workgroups provide feedback for development and implementation of quality and utilization management initiatives, measurements, interventions, and guidelines for improvement.

The workgroups include leadership and staff from Utilization Management, Case Management, Quality and Health Informatics, Government Programs and Compliance. Committees may also engage specialty consultants and the BH organization delegate to provide additional feedback for program changes, clinical practice guidelines and coordination with medical management and disease management interventions.

6.1.3 Behavioral Health Covered Services For Adults Enrolled in Medicaid Managed Care

The following BH services are covered for adults age 21 and older who are enrolled in a Medicaid managed care plan:

- Medically supervised outpatient withdrawal services
- Outpatient clinic and opioid treatment program

- Outpatient clinic services
- Comprehensive psychiatric emergency program (CPEP)
- Continuing day treatment program (CDTP)
- Partial hospitalization program (PHP) - *does not include partial hospitalization for substance use disorder treatment*
- Personalized recovery oriented services (PROS)
- Assertive community treatment (ACT)
- Health home care coordination and management
- Inpatient hospital detoxification service
- Inpatient medically supervised inpatient detoxification
- Inpatient treatment services (OASAS)
- Inpatient rehabilitation services
- Rehabilitation services for residential substance use disorder treatment supports (OASAS)
- Outpatient substance use disorder rehabilitation services
- Inpatient psychiatric services (OMH)
- Intensive outpatient treatment (IOP)
- Crisis intervention
- Intensive psychiatric rehabilitation treatment (IPRT)

6.1.4 Annual Review of Behavioral Health Programs

Each year, Excellus BlueCross BlueShield evaluates the performance data from BH utilization management, quality management and compliance programs. The purpose is to measure the department's effectiveness in servicing members seeking BH services. The BH departmental standards are reviewed on a regular basis to ensure that there is inclusion of recent changes and updates from Excellus BlueCross BlueShield's accreditation and regulatory entities.

6.2 Behavioral Health Member Requirements

6.2.1 Checking Eligibility and Benefits

Participating BH practitioners should always check a member's eligibility for BH benefits using any of the inquiry systems described in the *Administrative Information* section of this manual. Please note that some services for Medicaid managed care members ages 21 and under are covered as a Medicaid fee-for-service benefit.

6.2.2 Referrals and Preauthorizations

For most benefit programs, a member may self-refer to participating providers and facilities for outpatient substance use and mental health treatment. There are no referrals required for Medicaid managed care and Child Health Plus for mental health and substance use disorder services.

BH practitioners should determine if any service for any member requires preauthorization before providing the service. Refer to our preauthorization guidelines at ExcellusBCBS.com/ProviderAuthsGuidelines.

Note: for Medicaid managed care members, emergency mental health services, including comprehensive psychiatric emergency program (CPEP), are not subject to preauthorization. Crisis intervention and OMH/OASAS-specific non-urgent ambulatory services are not subject to preauthorization.

6.2.3 Emergency Behavioral Health Calls

When an Excellus BlueCross BlueShield member calls Customer Care with an emergency BH issue, the member will be connected via telephone prompt or connected by a Customer Care advocate to a BH Customer Care advocate, without placing the member on hold. When the BH Customer Care advocate receives a call identified as potential crisis, or that could escalate into a crisis, the caller will be warm transferred, without placing the member on hold, to a qualified BH clinician or triage nurse if after-hours, who will assess the nature of the member's needs and will either warm transfer the call to the local crisis provider, call 911 or available mobile crisis unit, refer the member for services, refer the member to his or her health care provider, or resolve the crisis over the telephone as appropriate. The BH clinician will also coordinate any appropriate follow-up with the member.

6.3 Outpatient Treatment F

6.3.1 Outpatient Mental Health Treatment

Excellus BlueCross BlueShield provides outpatient coverage for mental illness when treatment is medically necessary. Please visit our website, ExcellusBCBS.com/Provider, to view policies related to the delivery, management and oversight of outpatient BH services. These policies can also be requested by calling Customer Care.

Recommended Procedures for Practitioners/Facilities

A member contacts a participating BH provider to make an appointment to receive care. The provider/member may or may not be required to obtain preauthorization (refer to the preauthorization guidelines on our website, ExcellusBCBS.com/ProviderAuthsGuidelines).

Prior to meeting with the member, the provider should determine the member's eligibility and benefits via any of the inquiry methods described in the *Administrative Information* section of this manual.

To avoid providing BH services when benefits may be limited or exhausted, the provider should ask the member if he/she has seen other providers in the current calendar year, and for how many sessions.

During the member's initial visit, the provider performs an assessment. Providers must ask members to give written consent for sharing information with the member's PCP and other BH practitioners currently providing treatment as well as for securing information from practitioners that recently provided treatment, and document the member's response to previous treatment in the record.

Providers must coordinate care with the PCP and other practitioners (as necessary) to ensure that the patient receives a seamless, appropriate level of care, and that there is an exchange of information for continuity between medical and BH care.

Referral or Preauthorization

The majority of Excellus BlueCross BlueShield members do not require a referral or preauthorization for outpatient BH services. A complete list of services requiring preauthorization is available via our website, ExcellusBCBS.com/ProviderAuthsGuidelines, or by calling Customer Care. The PCP, BH practitioner, or member may initiate the first referral for outpatient mental health treatment for member contracts requiring preauthorization.

If a referral is needed:

- The PCP or BH practitioner contacts the appropriate referral number (see *Contact List* in this manual) to generate an authorization for visits to the practitioner.
- Practitioners are encouraged to screen appointment requests to determine if they are the appropriate practitioner to meet the patient's needs.

Outpatient Medical Management Process

We may use telephone reviews and/or request outpatient treatment records to manage partial hospitalization programs (PHP), using InterQual, and psychiatric testing in accordance with the Corporate Medical Policies to ensure that the care is medically necessary.

The requirements of federal mental health parity may not apply to some member contracts, but these contracts may have a provision for New York state mental health parity (Timothy's Law). In those cases, the BH department will conduct a telephonic review to establish if the member meets the guidelines of Timothy's Law and see if the treatment is medically necessary. At times, our board-certified doctors will conduct a peer-to-peer call to discuss the plan of care. If the member's contract includes the provision for Timothy's Law, but the member has exhausted his/her benefit and does NOT have a diagnosis that meets criteria for an extension of benefits, subsequent claims will be denied due to benefit exhaustion.

However, if the member does have a diagnosis that meets criteria that allows for an extension of benefits, BH staff will do a telephone review with the treating mental health practitioner to discuss the plan of care. The care must be well coordinated and medically necessary. The treatment record may be required in the event that telephone reviews cannot be arranged and/or a more thorough review is necessary.

In the event the BH staff and practitioner do not concur on the plan of care, the case is referred to a BH medical director, all of whom are board-certified psychiatrists. The BH medical director may conduct a phone review and/or request additional information.

6.3.2 Outpatient Substance Use Treatment

- Excellus BlueCross BlueShield covers outpatient substance use treatment (preferably, by Health Plan-credentialed BH practitioners). Most member contracts include a substance use benefit for treatment, but there are exceptions. (Contact Customer Care to determine eligibility.)
- Members do not need referrals or preauthorization to obtain covered **outpatient** substance use services under most member contracts. (Contact Customer Care to

determine member eligibility.) A member may self-refer to any *participating* outpatient substance use service provider (facility). BH practitioners should **always** check eligibility before providing service.

- A participating substance use provider may bill Excellus BlueCross BlueShield to obtain payment for treating the family of a substance use person. The substance use person does not have to be in treatment in order for the family member to access this benefit. There may be a limit on the number of visits that can be used for family treatment. (Contact Customer Care to determine eligibility.)

6.3.3 Outpatient Mental Health Therapy Groups

Outpatient mental health therapy groups require Health Plan review and approval prior to a member receiving these services. Groups can only be preauthorized if they have been approved through the Health Plan's BH department. Our group therapy forms can be found on our website, ExcellusBCBS.com/wps/portal/xl/prv/contactus/printforms.

Group therapy proposals are reviewed, researched and evaluated for evidenced-based treatment criteria in accordance with practice guidelines prescribed by corporate medical policy and group therapy standards as well as recommendations by the New York State Office of Mental Health and Department of Health, American Group Psychotherapy Association, National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, American Psychological Association and Behavior Tech LLC. The approval of evidenced-based group psychotherapies increases access to care for members with mental illness as well as members who are dual diagnosed with mental illness and substance use. This is of particular importance for members in remote areas where there may be less access to individual or facility-based mental health programming.

The BH department provides education to our members and providers in regards to our group therapy corporate medical policy and group therapy review process. The Group Therapy Resource Grid is updated on a regular basis as decisions are rendered on proposed groups. Direct feedback is given to providers when their groups do not meet the guidelines of our corporate medical policy. This feedback includes recommendations for revisions for resubmission of the group proposal when applicable.

6.4 Inpatient Treatment F

Note: For information about emergency room admissions, see the *Benefits Management* section of this manual.

Policy Overview

- When required by the member's contract and to the extent not prohibited by law, the provider must obtain preauthorization from Excellus BlueCross BlueShield for all partial hospital admissions for mental health and inpatient substance use treatment admissions (i.e., rehabilitation, residential). This means the member or provider should request authorization prior to admission.
- Urgent substance use treatment admissions (i.e., inpatient detoxification) may or may not utilize the BH benefit, depending on the type of facility to which the member is admitted. The admission may or may not require preauthorization, depending on the

member contract. Therefore, it is important for requesting providers to verify benefits and eligibility prior to a member's admission.

- The provider must obtain authorization for inpatient mental health services.
- Excellus BlueCross BlueShield routinely uses concurrent review in assessing inpatient admissions.

Procedures

Substance Use Treatment Center - Prior to admitting a member to a substance use treatment facility, a representative of the facility or the member's outpatient BH practitioner calls Customer Care to verify member eligibility and begin the preauthorization process, if applicable. This is forwarded to the BH department for additional clinical information required to support the inpatient referral. (See the *Contact List* in this manual for telephone numbers.) For most benefit programs, Excellus BlueCross BlueShield handles inpatient substance use rehabilitation as a non-urgent request; however, there are times when an urgent review is warranted. (See the *Benefits Management* section of this manual for information regarding *Utilization Review Time Frames*.)

OR

- **Mental Health Treatment Center –** Within 48 hours of admitting a commercial or Medicare member and within 24 hours of admitting a Medicaid managed care or HARP member to a mental health treatment facility, a representative of the facility calls Medical Intake to verify eligibility and benefits and to report that the member is receiving inpatient treatment. A member of the facility's clinical staff must then contact BH with clinical information to support the inpatient admission. (See the *Contact List* in this manual for telephone numbers.)
- The BH staff will perform the initial review with the inpatient facility to determine the medical necessity of the admission, necessary level of care, and approximate length of stay. BH staff reviewers assess services in accordance with nationally recognized criteria and corporate medical policies and do not automatically approve fixed lengths of stay at facilities.
- During the patient's stay, a BH reviewer will concurrently review the member's clinical presentation as often as deemed necessary. Following each review, Excellus BlueCross BlueShield will send a notice to the facility and the member indicating denial or approval of coverage of services, and the length of service approved.
- If the BH reviewer concludes that the inpatient admission or hospital stay does not meet BH criteria, the reviewer will discuss the case with a BH medical director. The BH medical director will make a determination or arrange for a clinical discussion with the member's attending physician before a decision is made.
- Payment is based on the terms of the member's contract and the provider's participation agreement.

6.4.1 What Inpatient Mental Health and Substance Use Residential Care Means

Mental Health Residential Treatment Facility: The facility must be either (a) a "residential treatment facility for children and youth" as defined in Mental Hygiene Law 1.03(33), or (b) a facility that is part of a comprehensive care center for eating disorders identified in accordance with Public Health Law Article 27-J; and for out-of-state facilities, the facility must be licensed or certified in that state to provide the same level of treatment. The facility must maintain general and malpractice insurance limits of $1/$3 million.

Substance Use Disorder Residential Treatment Facility: The facility must be OASAS-certified to provide services defined in 14 NYCRR 819.2(a)(1) and Part 817; and for out-of-state facilities, the facility must be licensed by a similar state agency or Joint Commission accredited as an alcohol, substance use, or chemical dependency treatment program to provide the same level of treatment.

These facilities must:

a. Be a licensed or certified mental health or substance use facility with a seven day per week, 24-hour highly-structured therapeutic setting.

b. Include the programming requirements listed in Excellus BlueCross BlueShield's Residential Treatment Corporate Medical Policy, which is available online at ExcellusBCBS.com/ProviderMedicalPolicies.

c. Be certified by the Office of Mental Health (OMH), Office of Alcoholism, Substance Abuse Services (OASAS), The Joint Commission Accreditation, Health Care and Certification (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF) or equivalent licensing agency out of state.

d. Be congruent with New York State Department of Financial Services model language as the intensive level of residential care. **In New York state, for child and adolescent mental health, Residential Treatment Facilities (RTFs) are a covered benefit per medical necessity guidelines while Residential Treatment Centers (RTCs) are not a covered benefit.**

e. Provide documentation of the differences in programming/staffing and use the appropriate billing code for the level of care provided for facilities providing multiple levels of care.

f. Document a process showing appropriate medical clearance, safety planning for the arrival of the patient, as well as robust engagement with the out-of-state family network, when these facilities encourage members to transfer treatment out of New York state.

g. Not be covered for the following residential levels of care: group homes, supportive housing, halfway houses, wilderness programs and school programs.

h. Be structured (if a specialty residential program) as an level of care with demonstrated evidence-based therapeutic interventions for the primary diagnosis

being treated, including, but not limited to, residential programs for obsessive compulsive disorder, borderline personality disorder, post-traumatic stress disorder, dissociative identity disorder, eating disorders and autism

i. Be residential treatment, which is a transitional, structured therapeutic environment that allows individuals to successfully reintegrate back home and into a lower level of care and is not considered a long term substitute for lack of available living environment.

j. Follow InterQual® for mental health, and LOCADTR for substance use, to determine medical necessity and length of stay in residential programs. To be transparent, these following pathways will be adhered to. You may view the full clinical criteria of these pathways, which are posted on our website, ExcellusBCBS.com/ProviderMedicalPolicies.

6.5 Utilization Clinical Review Management F

The BH Utilization Clinical Reviewers are a clinical care team that collaborates with the provider from the time of admission through the member's transition into outpatient care. Each level of care is based on given clinical information, nationally recognized criteria, McKesson Behavioral Health InterQual Level of Care Criteria or corporate medical policies, as well as best practices for mental health to determine medical necessity.

For substance use services delivered to our Commercial, Medicare, Child Health Plus and Medicaid managed care members; the Health Plan uses its corporate medical policies and the New York state LOCADTR tool to determine medical necessity.

This process results in establishing partnerships with the providers to promote continuity and coordination of care to maximize the effectiveness of the patient centered care.

In accordance with the Excellus BlueCross BlueShield Medical Advisory Committee, the utilization clinical reviewer provides pre-service, concurrent, and post-service review for mental health and substance use diagnoses in accordance with the Excellus BlueCross BlueShield line of business. This process facilitates access to high quality, medically necessary, cost-effective BH services, ensuring that members receive the highest standard of care in a timely and seamless manner, while assisting to fulfill the overall treatment needs for each individual member.

Excellus BlueCross BlueShield will not deny coverage of an ongoing course of care for Medicaid managed care members, unless an appropriate provider of an alternate level of care is approved for such care.

Excellus BlueCross BlueShield plans of care are the primary source for the utilization management process and the Health Plan complies with New York State Medicaid guidance, including managed care policy documents, relevant performance improvement specification documents or manuals and policies governing preauthorization, concurrent or retrospective review. Specifically, the Health Plan incorporates the following resources into its utilization management process:

- OMH Clinic Standards of Care
  www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html
- OASAS Clinical Guidance
  http://www.oasas.ny.gov/treatment/documents/ClinicalGuidance-Final.pdf

6.5.1 The Care Management Program

The Care Management program is fully integrated within the care management programs to manage the member's health along the health care continuum. This collaboration and integration includes BH utilization management, medical utilization management, care and disease management and pharmacy management staff. The team consists of qualified health care professionals with experience in BH. The BH Care Management program collaborates with members, providers and practitioners to maximize effective, person-centered treatment while maintaining cost-efficiency and effectiveness. The Care Management program targets those Medicaid managed care members who are at risk for or are diagnosed with depression.

Members are identified with various methodologies including HRA assessments so that the care managers are able to reach out to these members and effectively intervene using evidenced-based criteria. The BH Care Management program works with members with BH diagnoses in addition to members dually diagnosed with medical conditions such as cardiovascular disease, cancer, diabetes, COPD and asthma.

The intent of the program is to enhance the member's quality of life while supporting wellness through preventative strategies, education, and coordination of services and/or linkage with appropriate resources.

6.5.2 The Behavioral Health Advocate

The BH advocate is a resource when inpatient substance use services are denied. The advocate is responsible for helping to facilitate an appeal or help educate and coordinate an alternate level of care. The BH advocate will assist with navigating the insurance, if benefit searches or prior authorization is needed. They will monitor the use of medical and health care services for members, ensuring compliance with internal and external standards set by regulatory and accrediting entities.

This position supports the member and family. This person will collaborate with providers, members, family, and any other support system that can and will impact success for the member.

6.6 Quality Standards and Measures F

6.6.1 Clinical Practice Guidelines

Excellus BlueCross BlueShield researches adoption of clinical practice guidelines for the provision of BH services relevant to the populations served based on volume and the member's experience. Guidelines include information for the identification and referral of members with BH conditions to ensure that members receive care in settings where they are most likely to present.

The Quality Monitoring Committee (QMC) is responsible for the adoption and revision of clinical practice guidelines. All guidelines are reviewed and updated by the Quality Monitoring Committee upon significant new scientific evidence, change in national standards or at a minimum, every two years.

The Health Plan disseminates approved clinical practice guidelines to the practitioner network and enrollees in a timely manner through a variety of channels, which may include, however is not limited to, mail, email, fax, provider manual, provider newsletter, Excellus BlueCross BlueShield website and upon individual request. Upon revision of an established guideline, the Health Plan ensures appropriate communication of updates through the same distribution channels.

The Health Plan ensures that the adoption and revision process is consistent with and supports the utilization management authorization and approval process for all medical necessity services.

Clinical practice guidelines may include, but are not limited to:

- ADHD
- Depression
- Schizophrenia
- Bipolar disorder
- Substance abuse disorder
- Anxiety
- Trauma informed care
- Assertive community treatment
- Illness management and recovery
- Integrated dual disorder treatment for co-ocurring disorders
- Supported employment
- Family psychoeducation
- Tobacco cessation
- Office of Mental Health first episode psychosis practice guidelines
- Seeking safety
- Motivational enhancement therapy
- Twelve-step facilitation
- Cognitive behavioral therapy for substance use disorder
- Screening, brief intervention, and referral to treatment
- Medication-assisted treatment for substance use disorder

6.6.2 Behavioral Health Appointment Availability Standards

The following tables presents access standards for services provided by all BH practitioners and providers participating with Excellus BlueCross BlueShield. These standards are used by Excellus BlueCross BlueShield for quality and regulatory purposes as required by the New York State Department of Health and the National Committee for Quality Assurance.

BH Appointment Availability Standards: Commercial, Medicare and Managed Medicaid Care

Access Measure	Standards	Managed Care Organization Measurement Tool
Timeliness of routine BH care appointments	Should be available within 10 business days.	BH Member Experience Survey including Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Questions, and complaint analysis
Timeliness of BH urgent care appointments	Should be available within 48 hours.	BH Member Experience Survey including CAHPS questions and complaint analysis

BH Appointment Availability Standards: Commercial, Medicare and Managed Medicaid Care

Access Measure	Standards	Managed Care Organization Measurement Tool
Timeliness of BH emergency care	In life-threatening emergencies, a BH specialist should be accessible immediately by telephone, 24 hours a day, 7 days a week. In non-life-threatening emergencies, a BH specialist should be accessible within 6 hours.	Random After-hours Audit BH Member Experience Survey including CAHPS questions Complaint analysis
Timeliness of follow-up after inpatient hospitalization for a mental illness	Should be available within 7 calendar days following discharge.	HEDIS® measure*

* HEDIS, the Healthcare Effectiveness Data and Information Set, is a set of standardized performance measures designed to provide purchasers and consumers with information to reliably compare the performance of managed health care plans. HEDIS is sponsored, supported and maintained by the National Committee for Quality Assurance.

Additional BH Appointment Availability Standards: Medicaid Managed Care and HARP

Service	Emergency	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to Emergency or Hospital Discharge	Follow-up to Jail/Prison Discharge
Mental Health Outpatient Clinic/PROS Clinic		Within 24 hours of request	Within one week		Within five days of request	Within five days of request
ACT		Within 24 hours of request			Within five days of request	
PROS		Within 24 hours of request		Within two weeks	Within five days of request	Within five days of request
Continuing Day Treatment				Two to four weeks	Within five days of request	Within five days of request
IPRT				Two to four weeks		
Partial Hospitalization					Within five days of request	
Inpatient Psyc. Services	Upon presentation					
CPEP	Upon presentation					
Crisis Intervention	Upon presentation	Within 24 hours for short-term respite			Immediate	
Community Mental Health Services (599 clinic services offered in the community)		Within 24 hours of request	Within one week		Within five days of request	Within five days of request
OASAS Outpatient Clinic		Within 24 hours of request	Within one week of request		Within five days of request	Within five days of request
Detoxification	Upon presentation					
SUD Inpatient Rehab.	Upon presentation	Within 24 hours of request				
Opioid Treatment Program		Within 24 hours of request			Within five days of request	
Residential Addiction Services		Within 24 hours of request		Two to four weeks	Within five days of request	

After-hours Coverage

BH providers are required to provide necessary telephonic services to members 24 hours a day, 7 days a week in case of telephone calls from established patients or patients' family members concerning clinical mental health life-threatening emergency. This is critical for coordinating care when your patient has presented to the emergency room with an urgent/emergent or life threatening crisis. Providers must also arrange for complete backup coverage with other participating clinician(s) that can provide the same level of care in the event the practitioner is unable to provide covered services to established patients.

Excellus BlueCross BlueShield members must be able to:

- Reach the practitioner or a person with the ability to patch the call through to the practitioner (i.e., answering service, pager); or
- Reach an answering machine or voice mail with instructions on how to contact the practitioner or his/her backup (i.e., message with number for home, cell phone or beeper) in case of a clinical urgent/emergent situation. Call forwarding may also be used, but the message must state that the call is being forwarded to the practitioner's contact number.
- The practitioners answering machine messages is automatically forwarded to a phone (i.e., practitioners cell phone, pager) where the practitioner retrieves and responds to those messages for life-threatening emergencies, after-hours, as soon as possible.

Unacceptable answering for members when contacting you after-hours includes:

1. Reaching an answering machine that instructs the active member to go to the nearest emergency room, crisis center hotline, lifeline and/or call 911.
2. Reaching an answering machine with no instructions.
3. Reaching an answering machine recommending the member call during business hours.
4. No answer.
5. A busy signal three times, within 30 minutes.

To promote quality service to our membership, in conjunction with the delivery systems, Excellus BlueCross BlueShield needs to have compliance with this access standard. This standard is relevant to all lines of business.

- Failure to comply with the accessibility guidelines constitutes a material breach of your participating provider agreement, and may be cause for termination from the provider panel. Additionally, the New York Education Department Office of Professions and Code of Ethics for each discipline (i.e., psychiatrist, psychologist and licensed clinical social worker) support the after-hours accessibility guidelines for active members with a life-threatening emergency.

6.6.3 Continuity and Coordination of Care

Excellus BlueCross BlueShield monitors continuity and coordination of general medical care with BH care. The goal is for members to receive a seamless, continuous and appropriate level of care, as well as strengthen system-wide continuity between medical and BH care.

Our BH department collaborates with BH care practitioners, PCPs, pharmacies, other health care facilities, and medical providers to monitor and improve coordination between medical care and BH care. The BH department annually collects data and assesses the following six areas for collaboration between medical and BH care:

1. Exchange of information
2. Appropriate diagnosis, treatment, and referral
3. Psychopharmacological medication
4. Access and follow up of coexisting medical and BH disorders
5. Preventive BH guideline or program
6. Special needs of members with severe and persistent mental illness

Collaboration and communication between a BH practitioner and PCP and other appropriate treatment providers should occur no later than when the initial assessment is completed and a working diagnosis has been made; as well as when the initial plan of care has been completed. Providers are expected to document collaboration in the patient's chart. Collaboration encompasses coordination of care with the member's medical team. This may include, but is not limited to, the member's PCP, OB/GYN, surgeon, and/or other medical practitioner(s). A summary should be presented to the PCP with the patient's consent for release. Written consents are required by the NYSDOH.

We measure three critical components annually for continuity and coordination of care. They align with the previously listed five areas for collaboration between medical and BH care and are HEDIS measures, including:

- The first critical component of continuity and coordination of care is Excellus BlueCross BlueShield's mental health ***Follow-Up After Hospitalization for Mental Illness.*** Upon discharge from an inpatient psychiatric admission, Excellus BlueCross BlueShield requires the member to have an outpatient mental health therapy appointment within seven calendar days or five business days of discharge, according to the New York State Department of Health (NYSDOH), the Health Effectiveness Data and Information Set (HEDIS) and Excellus BlueCross BlueShield. Failure to adhere to this time frame may lead to readmission or emergency room visit(s). The HEDIS measures are supported by the NYSDOH, establishing the following guidelines and recommendations.

Note the following:

- A tour or orientation, in lieu of an initial mental health outpatient appointment, after a mental health hospitalization is not considered acceptable as a follow-up appointment, according to NYSDOH and national quality standards.

- When billing for a patient who begins a partial hospitalization program (PHP) the same day as a mental health hospitalization discharge, it should be billed as an outpatient PHP visit.

Inpatient mental health provider responsibilities:

- Begin discharge planning upon admission.

- Validate that the patient has an initial mental health follow-up appointment within seven calendar days **or** five business days from the date of discharge of his/her mental health hospitalization.

- Fax the discharge plan to the patient's primary care physician and outpatient mental health practitioner/clinic.

- Ensure that the patient has a copy of the discharge plan, agrees with and understands the plan.

- Confirm, prior to discharge, that the patient has the necessary resources to get to his/her initial follow-up appointment.

- Connect the patient to a Health Plan BH care manager as needed.

- Certify that the patient's initial follow-up appointment is for mental health therapy and/or mental health medication management with a mental health practitioner (i.e., LCSW, psychologist or psychiatrist).

- Do not bill for a hospital day if the patient is discharged that same day to PHP.

Outpatient mental health clinics, facilities or private practitioner's responsibilities:

- Ensure that the initial follow-up appointment you are scheduling for a patient, after a mental health hospitalization, is with a mental health practitioner.

- Document the date, time, patient's name and your name and credentials in the progress notes.

- Expect a Health Plan BH staff member to call to confirm whether the member has attended his/her initial follow-up appointment.

- HIPAA permits use or disclosure of PHI between payers and providers without authorization for mental health information.

- Encourage the patient to reschedule any cancelled initial follow-up appointments to be within seven calendar days or five business days from discharge.
- It is important to emphasize that care should be coordinated between all medical and mental health practitioners.

To connect your patient to a BH Care Manager, call 1-800-277-2198
Monday through Friday from 8 a.m. to 5 p.m.

- The second critical component is the ***Antidepressant Medication Management*** component. This measure looks at those members 18 years of age and older with a diagnosis of major depression that were newly treated with an antidepressant medication, and who remained on an antidepressant medication treatment for the following two rates HEDIS reports:

  a. *Effective Acute Phase Treatment* – Those members newly diagnosed and treated, who remained on an antidepressant medication for at least 84 days (12 weeks).

  b. *Effective Continuation Phase Treatment* – Those members newly diagnosed and treated, who remained on an antidepressant medication for at least 180 days (six months).

  Excellus BlueCross BlueShield requires practitioners to document (in the member's medical chart) continuity and coordination of care with the member's PCP and any other medical team members (i.e., OB/GYN, therapist).

- The third critical components are the four ***Schizophrenia and/or Bipolar*** HEDIS measures. According to HEDIS, which is supported and maintained by the National Committee for Quality Assurance (NCQA), patients dispensed an antipsychotic are *significantly* more likely to have a higher incidence of the illnesses listed below, as compared to those people not taking an antipsychotic.
  - Diabetes
  - Cardiovascular concerns
  - Higher level of blood cholesterol

  The four HEDIS measures include:

  1) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD). Members who are 18-64 years of age with schizophrenia or bipolar; who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
  2) Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD). Members who are 18-64 years of age with schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.

3) Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC). Members 18-64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.
4) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)*. Members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Excellus BlueCross BlueShield requires practitioners to document (in the member's medical chart) continuity and coordination of care with the member's PCP and any other medical team members (e.g., OB/GYN, therapist).

Follow-Up Care for Children Prescribed ADHD Medication (ADD)
Excellus BlueCross BlueShield expects participating providers to support children of newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication to have at least three follow-up care visits *within* a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

a. *Initiation Phase:* Members who are 6-12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, which had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

b. *Continuation and Maintenance (C & M) Phase.* Members who are 6-12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days after the Initiation Phase.

Excellus BlueCross BlueShield requires practitioners to document (in the member's medical chart) continuity and coordination of care with the member's PCP and any other medical team members (e.g., OB/GYN, psychiatrist, psychologist, therapist).

Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment

Excellus BlueCross BlueShield supports and expects participating providers to support this AOD HEDIS measure. The measure is for clients thirteen (13) years of age and older who have a new episode of alcohol or other drug (AOD) dependence who received the following:

a. *Initiation of AOD Treatment:* The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

b. *Engagement of AOD Treatment:* The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

For questions regarding BH quality standards and measures or to obtain an electronic version of the Behavioral Health Quality Provider Booklet or Tip Cards, contact Penny Weller, Accreditation, Compliance & Quality Administrator, at 1-800-240-6956, or by email at penny.weller@excellus.com.

6.6.4 HEDIS Measures

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
Excellus BlueCross BlueShield supports and expects participating providers to support this APC HEDIS measure. This measure is for children and adolescents between 1 – 17 years of age, who remain(ed) on two or more concurrent antipsychotic medications.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
Excellus BlueCross BlueShield supports and expects participating providers to support this APM HEDIS measure. This measure is for children and adolescents between 1 – 17 years of age, who had on two or more antipsychotic prescriptions and had metabolic testing.

6.6.5 Evidence-Based Assessment Resources and Tools

Behavioral Health (Mental Health & Substance Use)

- Depression Screening Tools
  - PH9-Q *Spanish* (PDF)
  - PH9-Q *English* (PDF)
  - PH9-Q Scoring Tool (PDF)

- **Anxiety Screening Tool**
  - GAD-7

- **Eating Disorder Tools**
  - Eating Disorder Assessment Form (PDF)
  - BMI Chart - Girls - age 2 to 20 (National Center for Health Statistics) (PDF)
  - BMI Chart - Boys - age 2 to 20 (National Center for Health Statistics) (PDF)

- **Alcohol Assessments**
  - CAGE-AID Questionnaire (PDF)
  - CRAFFT Questionnaire (PDF)

- Substance Abuse and Mental Health Services Administration

Mental Health

- Depression Guideline Adults in Primary Care
  Adopted the Institute for Clinical Systems Improvement, Inc. (ICSI) Health Care Guideline "Adult Depression in Primary Care Sixteenth Edition September 2013" Guideline reviewed April 2016.

- ADHD Guideline
  Adopted from the American Academy of Pediatrics December 2015. Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Assessment Five-step Evaluation and Triage (SAFE-T) app and pocket care for clinicians.

Substance Use

- Addiction & Misuse web page
  - Opioid Risk Tool
  - Cautious Evidence-based Opioid Prescribing
  - Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guideline
- National Alcoholism and Substance Abuse Information Center
- Clinical Opiate Withdrawal Scale (COWS)
- Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Excellus BlueCross BlueShield Participating Provider Manual

7.0 Billing and Remittance

This section describes billing and reimbursement policies and procedures that apply to benefit packages offered by Excellus BlueCross BlueShield. It includes instructions for submitting claims to Excellus BlueCross BlueShield, either electronically or on paper.

7.1 Electronic Submission of Claims Required F

In 1994, New York State enacted Public Health Law Section 2807-e(4) requiring hospitals, outpatient clinics, and physicians to submit health care claims to third-party payers electronically, using electronic formats designated by the New York State Department of Health. These formats have since been replaced by federally required formats (see below). However, the requirement to submit electronically still exists. Physicians who annually submit fewer than 1,200 claims to third party payers for direct payment were exempted from this requirement, but only upon obtaining a waiver from the Department of Health.

The federal Health Insurance Portability and Accountability Act (HIPAA) also include provisions affecting claims submission. While HIPAA does not require providers to submit claims electronically, it requires all providers who submit claims electronically to do so using national HIPAA claims formats and standards.

All hospitals, outpatient clinics and physicians in New York *who have not obtained a waiver* from the Department of Health must submit claims to payers electronically using HIPAA claims formats and standards. In addition, any other provider who submits claims electronically must do so using HIPAA-compliant electronic formats. See paragraphs under heading *How to Submit Electronic Claims* for more information about submitting claims electronically.

7.2 General Requirements for Claims Submissions F

- Claims must be completed accurately and in full, in accordance with the instructions presented in this manual. (See subsequent paragraphs.) Excellus BlueCross BlueShield cannot pay claims that are inaccurate or incomplete.
- Procedures must be identified by Current Procedural Terminology (CPT-4)[1], HCPCS or ICD-PCS codes. Diagnoses must be identified by ICD-CM[2] diagnosis codes.

[1]The AMA is the owner of all copyright, trademark and other rights to CPT and its updates. AMA reserves all rights.

[2]ICD-CM refers to the clinical modification (CM) of the most recent revision of the *International Classification of Diseases,* a book that lists diagnosis codes according to a system assigned by the World Health Organization of the United Nations. The ICD is distributed by the U.S. Printing Office in Washington, DC, and by commercial publishers.

Note: CPT, ICD-CM, ICD-PCS and HCPCS codes are revised at various times of the year by the organizations responsible for them, the Centers for Medicare & Medicaid Services (CMS) and/or the American Medical Association (AMA). Excellus BlueCross BlueShield accepts these codes as implementation dates are designated by these organizations.

- Place of service (POS) must be identified using the codes established by CMS. These codes apply to paper submittals of professional claims. Valid place of service codes for electronic submittals are included in providers' implementation guides for HIPAA-compliant electronic transactions.
  www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
- Procedures and diagnoses should be coded to the highest degree of specificity: for example, include 4th and 5th digits on ICD-CM codes when applicable.
- Claims with referral or prior authorization requirements must include the authorization number.
- Facility billers must include a revenue code to identify services rendered.
- All required supporting material must be made available to Excellus BlueCross BlueShield upon request.
- **Claims submitted to all payers, including Medicare, must include an NPI to identify each provider for which data is reported on the claim.** Excellus BlueCross BlueShield cannot accept any claims that do not include an NPI.
- Taxonomy codes are required on all claim submissions. Claims submitted without taxonomy codes will be returned. Providers may have multiple taxonomy codes and should only include the taxonomy code that applies to the services performed and reported on the claim submission.

7.2.1 Timely and Accurate Filing

Excellus BlueCross BlueShield requires that participating providers submit claims in a timely manner.

- Participating providers should submit all claims as soon as possible after rendering service (or after the processed date of a primary payer's explanation of benefits, or EOB). Most participating provider agreements contain a time limit within which claims will be accepted. Claims submitted after that time limit may be denied for late filing. ***Providers should review their participating provider agreements for these time limits.*** In the event of a declared pandemic, Excellus BlueCross BlueShield may extend the time limit to one year from date of service.
- Excellus BlueCross BlueShield will reject claims with incorrect or incomplete entries in required fields outlined in later paragraphs regarding submittal of electronic claims and paper claims. For example, Excellus BlueCross BlueShield will reject all claims submitted without member ID numbers.

7.2.2 Accurate and Complete ICD-CM Diagnosis & ICD-PCS Procedure Coding

So that claims may process appropriately, it is important that submitters enter accurate and complete ICD-CM diagnosis and ICD-PCS procedure codes on all claims. Excellus BlueCross BlueShield encourages participating providers to follow the *Tips for Accurate and Complete Diagnosis Coding* procedures available on our website, ExcellusBCBS.com/ProviderCodingBilling.

7.2.3 Using Modifiers

Excellus BlueCross BlueShield requires providers to use appropriate modifiers applicable to CPT codes and HCPCS codes when submitting claims. Using the right modifier may affect how the claim is paid.

There are certain instances where use of modifiers -25 or -59 is not appropriate. Excellus BlueCross BlueShield has established guidelines for these circumstances. The guidelines are available on the website or from Customer Care. To access via our website, go to ExcellusBCBS.com/ProviderCodingBilling.

Complete information about CPT codes and their modifiers is found in the most current issue of the American Medical Association (AMA) manual on current procedural terminology (CPT). Complete information about HCPCS (Health Care Procedure Coding System) codes and their modifiers is available through the website, cms.hhs.gov/MedHCPCSGeninfo/, or from various publications about the codes.

7.2.4 Additional References to Support Accurate Claims Submission

In addition to this manual, providers should refer to the following materials for information regarding claims submission.

- ***Participating Provider Agreement.*** The Participating Provider Agreement describes the provider's rights and obligations with respect to claims submission to Excellus BlueCross BlueShield. This manual is intended to clarify provisions of the Agreement. *In the event of a conflict between the provisions of this manual and a Participating Provider Agreement, the Agreement supersedes this manual.*
- ***Current Procedural Terminology (CPT).*** CPT code books list descriptive terms and identifying CPT codes for reporting medical services and procedures performed by providers. Excellus BlueCross BlueShield requires the use of these codes on claims. CPT codes and all CPT materials are copyrighted by the American Medical Association.
- ***International Classification of Diseases, Procedure Coding System (current version).*** ICD-PCS is a classification system that arranges procedures into groups according to established criteria. ICD-PCS codes are required for reporting procedures to all CMS programs. Excellus BlueCross BlueShield also requires the use of these codes.

- ***International Classification of Diseases, Clinical Modifications (current version).*** ICD-CM is a classification system that arranges diseases and injuries into groups according to established criteria. ICD-CM codes are required for reporting diagnoses and diseases to all CMS programs. Excellus BlueCross BlueShield also requires the use of these codes.
- ***HCPCS Level II National Codes.*** HCPCS is the acronym for the HCFA (CMS) Common Procedure Coding System. This system is a uniform method for health care providers and medical suppliers to report professional services, procedures, and supplies. Excellus BlueCross BlueShield requires use of HCPCS codes and associated modifiers for certain kinds of claims.
- ***InterQual® Criteria.*** InterQual Criteria are guidelines for screening the appropriateness of medical interventions. The criteria are the property of McKesson Health Solutions LLC. McKesson owns the copyright. Excellus BlueCross BlueShield uses InterQual guidelines in evaluating inpatient appropriateness of care.
- ***CMS Website*.** The CMS website is an extensive resource for forms, information and training materials associated with claims submission. The Web address is https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html.

7.2.5 Claims for Sterilization or Hysterectomy – Government Programs

There are special requirements for submitting a claim for sterilization or hysterectomy procedure performed on a member in Medicaid managed care. The performing provider must send a copy of the completed *Sterilization Consent Form* or *Acknowledgement of Receipt of Hysterectomy Information* form to Excellus BlueCross BlueShield either prior to submitting a claim for the procedure or with the claim for the procedure. **Excellus BlueCross BlueShield will deny payment for sterilization procedures or hysterectomy if the physician fails to submit evidence of informed consent given within the required time frames.** See specific information regarding the procedures, where to get forms, and the time frames for submittal in the *Government Programs* section of this manual.

7.2.6 Vaccines for Children Claims

All providers administering vaccines to children under age 19 covered by HMOBlue Option, Blue Choice Option or Child Health Plus must participate in the New York Vaccine for Children (NYVFC) program. NYVFC provides the vaccines to the physician free of charge. For more information about VFC and how to get vaccines, providers should call VFC directly. The eligible vaccines are listed on the CDC website. (The telephone number for NYVFC and the website for the CDC VFC program are included on the *Contact List* in this manual.)

While Excellus BlueCross BlueShield will reimburse for administration of the vaccines for HMOBlue Option, Blue Choice Option or Child Health Plus, claim history is needed for quality measures and compliance reporting to the DOH. Therefore, in addition to billing for vaccine administration, providers should also submit vaccine codes for quality reporting indicators for childhood immunization. Only vaccines that are listed on the state's immunization schedule are included in the VFC program.

VFC applies only to children with HMOBlue Option, Blue Choice Option or Child Health Plus coverage.

7.3 How to Submit Electronic Claims

Excellus BlueCross BlueShield accepts electronic claims through a clearinghouse. For information about how to submit electronic claims, including information about HIPAA claims formats and standards, call *eCommerce* at the number listed on the *Contact List* in this manual.

7.3.1 Filing Tips

- To support accurate and prompt claims processing, providers must use the correct Payer Identification Number (Payer ID) when submitting claims electronically.
- All required fields must be populated. If any required field has no entry, the clearinghouse will reject the claim.
- Use valid codes in fields such as those defining relationship, sex and place of service. If the code entered does not match the type of service being billed, the claim may pend and require manual intervention to be processed.

Claims submitted to all payers, including Medicare, must include an NPI to identify each provider for which data is reported on the claim.

7.3.2 Response Reports

Following submission of electronic claims, the provider will receive three reports:

- **Clearinghouse Acknowledgment Report.** This report indicates whether the transmission was successful.
- **Clearinghouse Response Report.** This report validates claims and lists both accepted and rejected claims.
- **Payer Response Reports.** Each type of claim — indemnity, managed care, etc. — will have its own Payer Response Report. These reports will be available within 24 to 48 hours after submission and will list only rejected claims.

Providers must review these reports, identify those claims that were rejected and correct the errors and resubmit the claims.

A provider should not consider that the clearinghouse has accepted an electronic claim until he/she has received all three reports, and the Payer Response Report shows that the claim was not rejected. Providers are encouraged to keep copies of these reports to help verify claims submission.

7.3.3 Secondary Claims

The clearinghouse can accept secondary claims that are submitted electronically, including those where Medicare is primary. See the paragraphs *Payment and Other Party Liability (OPL)* under the heading *Coordination of Benefits* for a list of what must be included in the claim in order for Excellus BlueCross BlueShield to process a claim for which it is secondary payer.

> **Note:** Not all vendors have the capability to submit secondary claims electronically. Before selecting or switching vendors, provider offices should contact *eCommerce* to determine whether a specific vendor has this capability.

7.3.4 Electronic Submittal of Medicare Part A Crossover Claims

Providers should not send claims to Excellus BlueCross BlueShield if the primary payer is Medicare. Medicare forwards balances to Excellus BlueCross BlueShield as secondary payer, after its payment. If the Explanation of Medicare Benefits (EOMB) from Medicare indicates that the claim has been forwarded to Excellus BlueCross BlueShield for processing, providers should suppress the secondary billing of these claims.

Providers who do not receive payment from Excellus BlueCross BlueShield for a balance after a Medicare Part A claim should wait a minimum of 30 days from the Medicare payment date before submitting the claim to Excellus BlueCross BlueShield. This will help avoid duplicate claims. Excellus BlueCross BlueShield will not service Medicare Part A claims for secondary payment before the 45-day time period has elapsed.

7.3.5 Electronic Submittal of Medicare Part B Crossover Claims

Medicare forwards Part B claims to Excellus BlueCross BlueShield as secondary payer. Providers who submit secondary claims electronically should suppress the secondary billing of Medicare-balance claims when the Medicare EOMB indicates the claim has been forwarded to Excellus BlueCross BlueShield.

Providers who do not receive payment from Excellus BlueCross BlueShield for a balance after a Medicare Part B claim should wait a minimum of 30 days from the Medicare payment date before submitting the claim to Excellus BlueCross BlueShield. This will help avoid duplicate claims. Excellus BlueCross BlueShield will not service Medicare Part B claims for secondary payment before the 45-day time period has elapsed.

7.4 How to Submit Paper Claims F

There are two types of paper claim formats:

- CMS-1500 for most professional services
- UB-04 (CMS-1450) for hospital and other facility services

As stated earlier, all hospitals, outpatient clinics and physicians in New York *who have not obtained a waiver* must submit claims to payers electronically, using HIPAA claims formats and standards. (See preceding information about electronic claims submission.) In addition, the requirements related to the national provider identifier (NPI) apply to paper claims as well.

Providers that submit on paper must do so according to the general requirements listed below under the heading *General Paper Claim Requirements.*

As stated in those requirements, claims submitted to all payers, including Medicare, must include an NPI to identify each provider for which data is reported on the claim.

7.4.1 Paper Claim Requirements

Excellus BlueCross BlueShield uses Optical Character Recognition (OCR) technology to read most paper claims. The following are important points to observe so that a paper claim may be processed using OCR rather than manually. Following these guidelines helps ensure timely processing.

- Use original forms that are printed in red. Do not use photocopies.
- Do not use red ink to fill in data field or attachment information. OCR equipment does not recognize red ink.
- Entries should be typed and dark enough to be legible. Change the toner cartridge in your printer regularly.
- So that information prints in the appropriate field, forms should be properly aligned prior to printing.
- When submitting multi-page claims, submitters must ensure that identifying information for both the provider and patient (Provider ID, NPI, patient account number, etc.) is reproduced and consistent on all pages.
- Use these guidelines when including attachments, such as medical records or primary payer information.
- Submit paper claims to the claims address specified on the *Contact List* in this manual.

For more information about accurate submission of paper claims, contact Customer Care.

7.4.2 Professional Services

The CMS-1500 form entitled *Health Insurance Claim Form* was designed for use by non-institutional providers and suppliers.

Excellus BlueCross BlueShield follows New York State Insurance Department claim submission guidelines in determining what constitutes a complete, or "clean," claim, unless stated otherwise in a provider's participating provider agreement. See *Clean Claim Guidelines* below.

7.4.3 New York State Clean Claim Submission Guidelines for CMS-1500

In addition to the NPI requirements, the New York State Insurance Department has *claim submission guidelines* (Regulation No. 178, 11 NYCRR 230.1) that help interpret the prompt pay law. Excellus BlueCross BlueShield follows these guidelines in determining what constitutes a complete, or "clean," claim, unless stated otherwise in a provider's participating provider agreement. The guidelines specify that:

- A health insurer cannot reject a claim submitted on a CMS-1500 claim form as incomplete if the claim contains accurate responses in specified fields, unless otherwise specified.
- In situations where one or more of the required fields is not appropriate to a specific claim, the submitter may leave the field blank.

Additionally, the guidelines state that Excellus BlueCross BlueShield may request additional information other than that on the claim form if this information is needed to determine liability or make payment. In other words, depending on the service being billed, **there may be other fields that Excellus BlueCross BlueShield requires for processing**. Further, Excellus BlueCross BlueShield is not prohibited from determining that a claim is not payable for other reasons.

7.4.4 Hospital and Other Facility Services

CMS-1450, the UB-04 uniform billing form, is most commonly used by hospitals, skilled nursing facilities, home health agencies and other selected providers to submit health care claims on paper.

Providers that submit on paper using the UB-04 must do so according to the general requirements listed above under the heading *Paper Claim Requirements*.

Excellus BlueCross BlueShield's requirements for the completion and submission of the UB-04 claim form are, for the most part, consistent with Medicare, Medicaid, and other major payers.

To support accurate completion of UB-04 forms, providers should refer to the following:

- The contractual arrangements between Excellus BlueCross BlueShield and the provider as described in the participating provider agreement.
- CMS requirements, as specified in the instructions for form CMS-1450 can be found on the CMS website, https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html.
- The chart, *UB-04 Field Descriptions,* at the end of this section of the manual.

7.4.5 Submitting Claims for Mid-Level Practitioners

When submitting claims to Excellus BlueCross BlueShield, mid-level practitioners — i.e., Nurse Practitioners (NPs), Physician Assistants (PAs) Certified Registered Nurse Anesthetists (CRNAs) — should follow these billing guidelines:

- **Billing as "Rendering Provider" (not incident to):** When billing mid-level practitioners services as rendering provider, the rendering provider information should be indicated in field 24 on the CMS Form 1500 paper claim. The supervising (or billing) provider's NPI should be indicated in field 33a on the CMS Form 1500 paper claim.

  For the ANSI 837 electronic claim, supervising provider information should be indicated in loop 2310D and the supervising provider's NPI would be indicated in loop 2310D, segment NM1.09. The billing provider information should be the same as the supervising provider/group information.

- **Billing "Incident to:"** Excellus BlueCross BlueShield follows Medicare guidelines for billing mid-level practitioner services performed incident to physician services. In such cases, the mid-level practitioner's incident to services are to be billed using only the collaborating/supervising physician's provider ID number indicated in field 24J on the CMS Form 1500 paper claim.

  For the ANSI 837 electronic claim, supervising provider information should be indicated in loop 2310D and the supervising provider's NPI would be indicated in loop 2310D, segment NM1.09. The mid-level practitioner should not submit another claim for himself/herself.

- **Taxonomy Code:** When billing for services rendered, mid-level practitioners must include the taxonomy code used to register their NPI number through the CMS website. Claims submitted without taxonomy codes will be returned.

- **Billing Modifiers:** Excellus BlueCross BlueShield requires providers to use appropriate modifiers applicable to CPT codes and HCPCS codes when submitting claims. Using the correct modifier may affect how a claim is reimbursed.

7.5 Claims Processing

7.5.1 Prompt Payment Law

Note: Agreements with specific groups may include more rigorous prompt pay requirements. In the absence of such an agreement, NYS law governs prompt pay requirements.

Under New York State prompt payment law, Excellus BlueCross BlueShield is required to decide, within 30 calendar days after receipt of a claim, whether to pay, deny, or require additional information.

- Excellus BlueCross BlueShield requires providers to submit a "clean" claim (see above).
- If adjudication leads to the decision to pay the claim, Excellus BlueCross BlueShield will pay an electronically submitted claim within 30 calendar days after receipt, and will pay a paper claim submission within 45 calendar days. Providers should not resubmit before the applicable time period is up, unless the claim has denied or returned unprocessed due to being incomplete.
- If Excellus BlueCross BlueShield pays a claim more than 30 calendar days (electronic submission) or more than 45 calendar days (paper submission) after receiving it, Excellus BlueCross BlueShield *in most cases* will apply interest at the annual rate set by the Commissioner of Taxation or 12 percent, whichever is greater. Excellus BlueCross BlueShield will make adjustments and/or pay interest when a claim was incorrectly paid due to Excellus BlueCross BlueShield error, but only if the original claim was "clean."
- If adjudication leads to the decision to deny the claim, Excellus BlueCross BlueShield will notify the claimant within 30 calendar days of receipt of the claim and include an explanation of why the claim was denied.
- If adjudication requires more information regarding the claim, Excellus BlueCross BlueShield will submit to the claimant a detailed request for such information within 30 calendar days following receipt of the claim.
- Excellus BlueCross BlueShield periodically performs prompt pay audits, and as a result of those audits a reconciliation of prompt pay interest paid to you may be required. If necessary, Excellus BlueCross BlueShield will contact you regarding these audits.

7.5.2 Fee Schedules

Excellus BlueCross BlueShield pays a participating provider for covered services provided to its members on the basis of a fee schedule pursuant to the terms and conditions of the provider's participation agreement. For more information about fee schedules, see the *General Provider Information* section of this manual.

Excellus BlueCross BlueShield deducts copayments, coinsurance, and permitted deductibles from the amount to be reimbursed, as applicable. These amounts are determined from the member's benefit package, the product lines in which the provider participates, and the terms established in the provider's participation agreement with Excellus BlueCross BlueShield.

Fee schedules appropriate to a specific participating provider are available upon request from Customer Care. (For contact information, see the *Contact List* in this manual.) In addition, physicians may access commercial fee schedule information via our website at ExcellusBCBS.com/ProviderCodingBilling.

7.5.3 Clinical Editing

As part of the claims adjudication process, Excellus BlueCross BlueShield's claims systems will review the claim to determine that it fulfills Excellus BlueCross BlueShield medical policies, referral requirements, preauthorization requirements (including those for medical necessity) and other benefit management specifications.

Excellus BlueCross BlueShield uses clinical editing criteria based on code edits recommended by multiple sources for the purpose of coding accuracy. The two principal sources are the American Medical Association's Current Procedural Terminology (CPT) publications and the Centers for Medicare & Medicaid Services national Correct Coding Initiative (CCI).

Excellus BlueCross BlueShield may also use standards derived from evidence-based guidelines for medicine and clinical appropriateness that are developed by its medical staff and other medical professionals. These medical policies outline Excellus BlueCross BlueShield's determination of the appropriate use of medical services. Medical policies are available on our website, ExcellusBCBS.com/ProviderMedicalPolicies, or upon request from Customer Care. (For contact information, see the *Contact List* in this manual.)

Excellus BlueCross BlueShield has incorporated clinical editing software into its claims systems. This software is used to determine the accuracy of procedural and diagnostic coding. The systems detect irregularities such as:

- **Unbundled procedures.** Providers should not bill using several procedure codes when there is a single inclusive procedure code that describes the same services.
- **Incidental procedures.** Providers should not bill separately certain procedures that are commonly performed in conjunction with other procedures as a component of the overall service provided. An *incidental* procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.
- **Mutually exclusive procedures.** Providers should not bill combinations of procedures that differ in technique or approach but lead to the same outcome. In some instances, the combination of procedures may be anatomically impossible. Procedures that represent overlapping services or accomplish the same result are considered mutually exclusive. Generally, an open procedure and a closed procedure performed in the same anatomic site are not both recommended for reimbursement. Mutually exclusive edits are developed between procedures based on, but not limited to, the following CPT descriptions: limited/complete, partial/total, single/multiple, unilateral/bilateral, initial/subsequent, simple/complex, superficial/deep, with/without.
- **Procedures inappropriate for gender, age, etc.**

To help avoid these errors, Excellus BlueCross BlueShield makes available some Web-based tools. One of the tools is a vendor-based tool. When used, it may provide information to participating providers regarding the manner in which Excellus BlueCross BlueShield's claim system adjudicates claims for specific CPT codes or combinations of such codes without regard

to a specific member's benefits, provider fee schedule, employer agreements, or unique provider-specific contractual terms. To access, visit ExcellusBCBS.com/ProviderCodingBilling.

Certain clinical edits will cause the system to generate a letter requesting additional information. Other clinical edits may result in a denial, which will appear on the provider's remittance advice. Providers may also initiate a provider inquiry related to the edit determination by completing the *Clinical Editing Review Request Form*, described below.

7.5.4 Clinical Editing Reviews

Providers who disagree with a clinical editing determination for a procedure code combination may request a clinical editing review. The *Clinical Editing Review Request Form* is available on the website or from Customer Care. To access the form, visit ExcellusBCBS.com/wps/portal/xl/prv/contactus/printforms/. Submit the form to the address listed on the form. In addition, disputes can be submitted online at ExcellusBCBS.com/ProviderCodingBilling (website login is required).

It is important to include any clinical documentation that will support the request. Excellus BlueCross BlueShield will make a determination on the review and notify the provider in writing within 45 days of receipt of all necessary information.

Unless otherwise stated in the provider's participation agreement, Excellus BlueCross BlueShield allows 120 days from the date that the provider received the original claim determination to request a review. Excellus BlueCross BlueShield's policy is to begin this 120-day time frame for review within five business days after the claim determination was sent to the provider.

7.5.5 Submission of Medical Records

Excellus BlueCross BlueShield may request submission of relevant medical records to facilitate reviews for:

- Services or procedures requiring preauthorization.
- Services or procedures where a corporate medical policy indicates criteria for medical appropriateness or for services considered cosmetic, experimental or investigational.
- Quality of care and quality improvement.
- Medical necessity.
- Pre-existing conditions.
- Determination of appropriate level of care.
- Case management or care coordination.

In addition, medical records may be needed for processing claims with:

- Modifier 22 (unusual procedural services) appended
- Modifier 52 (reduced services) appended
- Modifier 53 (discontinued procedure) appended
- Modifier 62 (co-surgeon) appended

For services billed with unlisted, not otherwise specified, miscellaneous or unclassified codes, a description of service is required. Additional records may be requested for these services, depending on the description provided.

In addition to the above, Excellus BlueCross BlueShield may request medical records relevant to:

- Credentialing and Coordination of Benefits.
- Claims subject to retrospective audit.
- Investigation of fraud and abuse or potential inappropriate billing practices in circumstances where there is a reasonable belief that such a need exists.

There may be additional individual circumstances when Excellus BlueCross BlueShield needs to request medical records to support claim processing.

You may be required to include medical records with your initial claim submission if the service requires review to determine medical necessity, including possible experimental/investigative services, under one of Excellus BlueCross BlueShield's Medical Policies. A listing of the codes that require up-front submission of records and the clinical information needed to perform the review is located on the website, at ExcellusBCBS.com/ProviderCodingBilling > *Submitting Medical Records*. If you do not submit the records as required, claims may be denied and you may be required to resubmit a new claim with the necessary information.

You will not be required to submit records for services if: preauthorization was obtained from Excellus BlueCross BlueShield; the services you rendered were for behavioral health or substance abuse; or the services were rendered under the BlueCard® program. Excellus BlueCross BlueShield will continue to request other records as needed for codes not on the list, or for other circumstances as described elsewhere in this manual.

Guidelines for up-front submission of medical records, including details on specific procedure codes and the records required for review, are on our website.

7.5.6 Retrospective Medical Claim Review

The purpose of medical claim review is to analyze whether a claim reflects services rendered, and to verify that the services rendered are appropriate to the clinical variables of each case, based on the standards of medical care, subscriber contract benefits and terms of participating provider agreements. This review includes:

- Reviewing supporting documentation to determine medical necessity post service.
- Reviewing coding/pricing as appropriate.
- Adhering to quality of care standards of care.
- Assisting with special studies such as the Healthcare Effectiveness Data and Information Set (HEDIS®), as designed or recommended by the Quality Management department; and
- Referring cases to Quality Management as needed.

Medical Necessity Review for Chiropractics

Excellus BlueCross BlueShield staff may ask to see charts as part of medical necessity review for chiropractics. Excellus BlueCross BlueShield uses corporate medical policy and a chiropractic consultant to perform chiropractic reviews.

To help chiropractors provide the type of information Excellus BlueCross BlueShield needs to pay claims appropriately for chiropractic services, Excellus BlueCross BlueShield has created some chiropractic documentation standards. The standards are available on the website (see ExcellusBCBS.com/wps/portal/xl/prv/contactus/printforms > *Ancillary Services*), or from Customer Care. Also available are descriptions, and instructions for use, of the clinical outcome tools that are a part of the standards.

The referenced tools discussed are available from a variety of sources, including the Internet. Most may be copied for use in an individual chiropractor's practice.

7.5.7 Coordination of Benefits - Excellus BlueCross BlueShield as Secondary Payer

Excellus BlueCross BlueShield subscriber contracts allow coordination of payments with other payers, when a member is covered by more than one health benefit programs. This is to prevent duplicate payment for health care services. The member's contract defines how Excellus BlueCross BlueShield implements coordination of benefits (COB) for that contract.

Excellus BlueCross BlueShield follows COB rules set forth by the New York State Insurance Department's regulations, as well as COB guidelines established by the National Association of Health Insurance Commissioners (NAIC). Medicare secondary payer rules take precedence.

Participating providers agree to accept Excellus BlueCross BlueShield's secondary payment for covered services and not balance-bill the member/subscriber in excess of deductibles, copays and/or coinsurance.

> **Note:** If a member has coverage under two (or more) plans that both require referrals, the member must have obtained a valid referral and/or authorization from each plan to which a claim will be submitted.

Excellus BlueCross BlueShield follows the procedures below in order to prevent duplication of payment, prevent overpayment for services provided when a member has health benefits coverage under more than one plan, and to clarify the order of primacy for Other Party Liability (OPL), Worker's Compensation, No Fault and Medicare claims.

General Adjudication Policies

Brief summaries of special, statutory-based claims adjudication policies are provided below. They are furnished only to provide information to providers in the context of this manual, and are not to be relied upon as definitive legal statements of the coverage requirements relating to these programs.

Benefits will be coordinated as follows when members are covered under Excellus BlueCross BlueShield and another health care benefit package.

- *When Excellus BlueCross BlueShield is primary*, it will reimburse the provider's billed charge or the fee schedule maximum (less any applicable copayment, coinsurance or deductible), whichever is less.
- *When Excellus BlueCross BlueShield is secondary*, it will reimburse the provider for Excellus BlueCross BlueShield covered services in conjunction with the primary plan, so that the two plans pay no more than 100 percent of charges or its fee schedule maximum (less any applicable copayment, coinsurance or deductible), whichever is less.
- If a member does not have a legal obligation to pay all or a portion of the provider's billed charges, then Excellus BlueCross BlueShield will have no obligation to pay any portion of the provider's billed charges.
- When Medicare is primary and denies the entire claim, and the claim is for covered services, Excellus BlueCross BlueShield will reprocess the claim as primary. All services provided will be subject to copayments, preauthorization, and all other Excellus BlueCross BlueShield policies regarding claims.
- When Excellus BlueCross BlueShield is secondary, the primary is not Medicare, there is a balance after the primary plan has made payment and Excellus BlueCross BlueShield or the other plan has reimbursed the fee schedule maximum for covered services, the provider may not balance-bill the patient even if Excellus BlueCross BlueShield makes no payment.

- As a secondary payer, Excellus BlueCross BlueShield will never pay more than it would have if it had been the primary health plan.

Workers' Compensation and Other Employer Liability Laws

Excellus BlueCross BlueShield health benefit programs exclude coverage for services obtained by a member as a result of injury or illness that occurs on the job. These expenses are covered under the state's Workers' Compensation Law.

Excellus BlueCross BlueShield will closely review claims for injuries or illnesses, to determine if they are work-related. If necessary, Excellus BlueCross BlueShield will send the member a questionnaire. Excellus BlueCross BlueShield will deny any claim determined to be work-related, and will notify the provider that he/she must file the claim through the applicable Workers' Compensation carrier or through the member's employer.

If Excellus BlueCross BlueShield mistakenly pays a claim on a work-related injury or illness, and later discovers that the injury or illness was work-related, Excellus BlueCross BlueShield will take legally-permissible steps to obtain appropriate recoveries from all parties who have received claims payments.

Medicare

An Excellus BlueCross BlueShield member continuing to work and remaining actively employed after age 65 will have as primary coverage either Medicare or an Excellus BlueCross BlueShield program provided by his/her employer or group, depending on the size of the group. This also

applies to the over-65 spouse of an active employee who is a member of Excellus BlueCross BlueShield.

Once an Excellus BlueCross BlueShield member is no longer an active employee or spouse of an active employee of an Excellus BlueCross BlueShield group, Medicare coverage becomes primary.

When Medicare is primary and Excellus BlueCross BlueShield is secondary, Excellus BlueCross BlueShield will pay up to its fee schedule.

No-Fault Claims

Excellus BlueCross BlueShield health benefit programs exclude coverage for services obtained by a member as a result of injury related to an automobile accident for members who reside in a mandatory no-fault state. These expenses are covered under the member's mandatory no fault benefits.

Excellus BlueCross BlueShield will closely review claims for injuries to determine if they are related to an automobile accident. If necessary, Excellus BlueCross BlueShield will send the member a questionnaire. Excellus BlueCross BlueShield will deny any claim determined to be related to the motor vehicle accident, and will notify the provider that he/she must file the claim through the no-fault insurance carrier.

If Excellus BlueCross BlueShield mistakenly pays a claim on a motor vehicle related injury, and later discovers that the injury was related to the motor vehicle accident, the Excellus BlueCross BlueShield will take steps to obtain appropriate recoveries from all parties who have received claims payments.

> **Note:** Excellus BlueCross BlueShield will consider claims if the no-fault insurance carrier's rejection was based on the carrier's independent medical examination. However, Excellus BlueCross BlueShield will deny claims that were not submitted within the no-fault timely filing limit or if a required authorization was not obtained for services provided. Excellus BlueCross BlueShield will send a letter of inquiry to the member to determine the status of his/her injuries and follow up with the member.

Payment and Other Party Liability (OPL)

Excellus BlueCross BlueShield reviews claims to determine the primary and/or secondary payer. Excellus BlueCross BlueShield may generate a COB questionnaire to help determine the coordination of benefits payment order.

To balance the amounts on secondary claims, Excellus BlueCross BlueShield requires the following figures from the primary carrier’s EOB:

- Charges
- Allowed amount
- Deductible and coinsurance applied
- Reduction of charges taken

- Payment amount
- Patient responsibility

  Note: If Excellus BlueCross BlueShield cannot balance the figures submitted, the claim will be denied until actual EOB information is provided.

- If it is determined that Excellus BlueCross BlueShield is the primary carrier, Excellus BlueCross BlueShield will process the claim and make payment for the covered services provided in accordance with the fee schedule.
- If Excellus BlueCross BlueShield is determined to be the secondary carrier, and no primary carrier payment information was submitted with the claim, Excellus BlueCross BlueShield will deny the claim. Providers should resubmit these denied claims to the primary carrier. After the primary carrier has made payment, the provider should resubmit the claim to Excellus BlueCross BlueShield for consideration of any balances due.

7.5.8 Inquiring About the Status of a Claim

Providers may use one of the inquiry systems described in the *Administrative Information* section of this manual to inquire about the status of a claim, or they may call Customer Care.

7.6 Remittance

A participating physician who submits claims for Excellus BlueCross BlueShield benefits plans receives a remittance advice that summarizes all claims processed since the last payment was made to the submitter.

> **Note:** Remittances may come in multiple envelopes. This occurs when a remittance exceeds the number of pages that Excellus BlueCross BlueShield's remittance processing system is able to mail in a single envelope.

7.6.1 When Additional Information is Required

For some claims, Excellus BlueCross BlueShield may need additional information before it can make a determination to cover or deny the service. These claims will be so marked on the remittance with a message asking him submitter to provide additional information. A provider has 45 days from the date printed on the remittance to submit supporting documentation related to the service in question.

7.6.2 Understanding the Remittance

The remittance includes details about each claim as well as:

- **Explanation Codes**. Providing the reasons why a specific claim has not been paid. Reasons for non-payment include denials and the need for more information. Explanation

codes associated with a specific claim are on the claim line; descriptions of what the codes mean are presented at the end of the remittance.

- **Adjustments**. All adjustments made to previously submitted claims are listed at the end of the remittance.
- **Recoupments**. All recoupments related to a remittance check will appear in the adjustment section, and the total dollars recovered will be shown.
- **OPL**. OPL payment amounts are indicated.
- **Procedure, Revenue, and DRG codes**. All codes will appear in the field, SERVICE**.** If both a procedure and revenue code was submitted for a claim, the SERVICE field will display the procedure code first, followed by the revenue code.
- **Patient Responsibility**. As applicable, is displayed in four fields: CO-PAY, CO-INS, DED, and OTHER. For members of PlusMed and Child Health Plus, these fields will be left blank.

7.6.3 Electronic Remittance Advice and Electronic Funds Transfer

We are pleased to offer InstaMed® for Electronic Payments (EFTs), Remittance Advice (ERA) and more, as a free service to our participating providers. You have two options for registering to receive EFT/ERA delivery: Complete and submit the InstaMed Network Funding Agreement, or visit instamed.com/eraeft and complete the online registration process.

Benefits of InstaMed:

- **Possible reduction in accounting expenses** - By importing electronic remittance advice from the Web directly into practice management or patient accounting systems, the need for manual re-keying is reduced or eliminated.
- **Improvement in cash flow** - Electronic payments can mean faster payments, resulting in improved cash flow. Paper checks will be discontinued upon enrollment.
- **Control of bank accounts** - Maintain total control of the destination of claim payment funds; multiple practices and accounts are supported.
- **Prompt match of payments to remittance advice** - Immediately associate electronic payments with electronic remittance advice. View remittance advice online and print it at your convenience.
- **Increase in reporting functionality** - Ability to create functional reports that support your internal needs.
- **Easier management of multiple payers**- Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts, as desired.

- **Reduction of paper usage** - Paper checks will be discontinued by the next pay cycle after enrollment. Paper remittances will be discontinued four weeks after enrollment with electronic funds transfer.

7.7 Requesting a Change in Claims Payment F

There are a number of circumstances after a claim has been processed that may require Excellus BlueCross BlueShield to take another look. These include incorrect payments or denials, or services billed incorrectly or in error.

7.7.1 Adjustments

Excellus BlueCross BlueShield has a claims adjustment process that providers may initiate *after the claim has been processed*.

Please note that ***claims returned to the submitter because they were inaccurate or incomplete have not been processed and consequently cannot be adjusted.*** This includes electronically submitted claims that don't pass edits at the clearinghouse or payer system. In addition, Excellus BlueCross BlueShield cannot adjust a claim when the dollar amounts change due to the provider's corrections (such as adding a service line or a modifier). A corrected claim must be submitted.

Policies

- Excellus BlueCross BlueShield will make adjustments when a claim is paid incorrectly due to Excellus BlueCross BlueShield error, but only if the original claim was "clean."
- If Excellus BlueCross BlueShield mistakenly underpays a provider for a claim, Excellus BlueCross BlueShield will make an adjustment on a subsequent remittance.
- Excellus BlueCross BlueShield calculates interest on adjustments in accordance with specifications of New York State prompt payment law.
- If Excellus BlueCross BlueShield mistakenly overpays a claim to a participating provider, Excellus BlueCross BlueShield will make an adjustment and deduct that amount from future payments.

  Note: Providers may also return overpayments to Excellus BlueCross BlueShield. See the paragraph below headed *Overpayments*.
- Review of a claim does not guarantee a change in payment disposition.

Procedure

Adjustments may be requested via:

- **Website.** Participating providers who are registered users of Excellus BlueCross BlueShield's website may request an adjustment electronically via an interactive form available on the website. Providers may also submit related additional information, such as medical records, electronically. To access go to ExcellusBCBS.com/ProviderCodingBilling > *Request an Adjustment*.

- **Paper *Request for Research/Claim Adjustment* form.** This form is available on the Excellus BlueCross BlueShield website or from Customer Care. To access via the website, go to ExcellusBCBS.com/ProviderCodingBilling *> Request an Adjustment > Request a Claim Adjustment by Mail or Fax.*

  Attach a copy of the remittance advice that included the claim, a copy of the original claim form, and other relevant supporting documentation. If a claim was denied for no authorization, but there **was** an authorization, the provider may use the *Request for Research/Claim Adjustment* form and attach a copy of the authorization.

- If a claim denied for timely filing, the provider should submit the Request for Timely Filing Review form with supporting documentation. A timely filing denial may be overturned if one of the situations listed on the Request for Timely Filing Review form applies, and the provider has sufficient supporting documentation for the situation.
  Please note: The Request for Research/Claim Adjustment form is not appropriate for questioning timely filing denials.

  The *Request for Research/Claim Adjustment* form is not appropriate for questioning edits made by our electronic claim review system or for questioning DRG reimbursement. See paragraphs below that address these issues.

- **Customer Care.** Representatives may be able to take information over the phone, in limited amounts, to initiate an adjustment. If documentation is required, provider may be advised to use the *Request for Research/Claim Adjustment* form.

7.7.2 Clinical Editing Review Requests

For certain claims, Excellus BlueCross BlueShield's claim systems may have determined that a procedure was mutually exclusive (or incidental) to a primary procedure. **The *Request for Research/Claim Adjustment* form is not appropriate for questioning the results of electronic claim review**. Instead, providers should use the *Clinical Editing Review Request* process described earlier in this section of the manual.

7.7.3 Overpayments

Excellus BlueCross BlueShield has a process for receiving returned overpayments in lieu of an adjustment on a subsequent claim. In order to credit the returned payment properly, Excellus BlueCross BlueShield requires the claim number, member or subscriber ID, and the date of service. Providers may supply this information separately or by including a copy of the applicable remittance.

Do not return overpayments for BlueCard claims or claims involving NYHCRA pools. Instead, notify Excellus BlueCross BlueShield in writing and include a copy of the remittance in question so that Excellus BlueCross BlueShield may initiate a retraction.

Overpayments must be mailed directly to the Credit and Collections Department. (See the *Contact List* in this manual for the correct address for this department.) The process

and address are also available on the website, as well as from Customer Care. To access online, go to ExcellusBCBS.com/ProviderPrintForms> *Overpayment Return Form*

As a reminder, if Excellus BlueCross BlueShield mistakenly overpays a claim to a participating provider, it will make an adjustment and deduct that amount from future payments. If the provider disagrees with Excellus BlueCross BlueShield's decision regarding the adjustment, the provider should contact his/her regional Customer Care department.

7.7.4 DRG Review Request

If a hospital needs Excellus BlueCross BlueShield to review the DRG reimbursement it received on a specific claim (or claims), it should use the *DRG Review Request Form*, available on the website or from Customer Care.

Please use this form only for paid claims that require review of the DRG paid versus the DRG submitted, or if you are questioning our DRG payment calculations. As stated on the form, the provider must also include a DRG calculation sheet and copy of the claim submittal (UB-04 or paper copy of electronic equivalent) with the form.

7.7.5 APC Review Request

If a hospital needs Excellus BlueCross BlueShield to review the APC reimbursement it received on a specific claim (or claims), it should use the *APC Pricing Dispute Form*, available on the website at www.ExcellusBCBS.com/wps/portal/xl/prv/contactus/printforms/, or from Customer Care.

Please use this form only if you are questioning our APC payment calculations or APC denial. As stated on the form, the provider must also include an APC calculation sheet and copy of the claim submittal (UB-04 or paper copy of electronic equivalent) with the form.

7.7.6 False Claims Act Reminder

Excellus BlueCross BlueShield expects participating providers to understand the state and federal requirements regarding false claims recovery. Providers participating with Medicare, Medicaid managed care and Child Health Plus are also obligated to report and return overpayments to the plan within 60 days of the time when the overpayments are identified. Information about our policies on false claims and overpayment procedures is available on our website.

7.8 Claim Form Completion F

7.8.1 Claim Form Completion Tools

Excellus BlueCross BlueShield offers tools to help with completion of the CMS-1500 and UB-04 CMS-1450 form. A tip book for completing the CMS-1500 can be accessed via our website, ExcellusBCBS.com/ProviderStaffTraining. In addition, the field descriptions for the UB-04 CMS-1450 are provided on the following pages.

UB-04 CMS-1450 Field Descriptions See notes at the end of this chart.		
Field	**Name**	**Entry**
1	Unlabeled	4 lines for Provider Name, Address, Telephone, Fax, Country Code (only if address/phone outside the U.S.)
2	Unlabeled	4 lines for Pay-to Name, Address, etc.
3a	PAT CTL #	Patient Control Number assigned to patient by provider
3b	MED REC #	Medical record number assigned to patient's medical record by provider
4	**TYPE OF BILL**	**4-digit code that identifies type of facility, bill classification (variations for hospital, clinic or special facilities), and frequency (indicates sequence of bill in particular episode of care).**
5	**FED. TAX NO.**	**Tax identification number (TIN) or employer identification number (EIN)**
6	**STATEMENT COVERS PERIOD (From/Through)**	**Enter beginning and ending dates of the period included on the claim**
7	Unlabeled (2 lines)	2 lines – not used
8a	PATIENT NAME - ID	Patient ID number (depending on primary, secondary, tertiary in field 60)
8b	**PATIENT NAME**	**Enter name of patient**
9	PATIENT ADDRESS	Lines a through e for street and number or box number, city, state, zip code and country code (if address outside the U.S.)
10	**BIRTHDATE**	**Enter patient's date of birth**
11	SEX	Enter F or M

UB-04 CMS-1450 Field Descriptions

See notes at the end of this chart.

Field	Name	Entry
12	**ADMISSION DATE**	**Date of admission or commencement of services**
13	ADMISSION HOUR	Time of day of admission or commencement of services
14	ADMISSION TYPE	Appropriate code for emergency, urgent, elective, newborn, etc.
15	ADMISSION SRC	Source of admission code
16	DHR	Discharge hour
17	STAT	Patient discharge status code
18-28	CONDITION CODES	Relate to type or lack of coverage
29	ACDT STATE	Accident state
30	Unlabeled (2 lines)	Not used – 2 lines
31-34	OCCURRENCE CODE and DATE	Enter applicable occurrence code(s) and associated date in lines a and b
35-36	OCCURRENCE CODE and SPAN (FROM/ THROUGH)	Enter applicable occurrence code(s) and associated date span in lines a and b
37	Unlabeled	Unused – lines a and b
38	Unlabeled	5 lines for responsible party/subscriber name and address
39-41	VALUE CODES and AMOUNTS (lines a through d)	Lines a through d. Value codes and amounts, including those for covered days (80), non-covered days (81), coinsurance days (82) or lifetime reserve days (83) should be placed here.
42	**REV CODE**	**Revenue code for each service billed – 22 lines**
43	DESCRIPTION	Revenue code description for each service billed – 22 lines
44	**HCPCS / RATE / HIPPS CODE**	**HCPCS or HIPPS code corresponding to each service billed – 22 lines**
45a	**SERV. DATE**	**Service date of each service billed – 22 lines**
45b	CREATION DATE	Date claim form is completed
46	SERV. UNITS	Service units corresponding to each service billed – 22 lines

UB-04 CMS-1450 Field Descriptions See notes at the end of this chart.		
Field	**Name**	**Entry**
47	**TOTAL CHARGES**	**Total charges for each service billed – 22 lines**
48	NON-COVERED CHARGES	Non-covered charges for each service billed – 22 lines
49	Unlabeled	22 lines – not used
47-48	TOTALS	Total amount of charges and total amount of non-covered charges
50	PAYER NAME	3 lines, one each for primary, secondary and tertiary payers.
51	HEALTH PLAN ID	This spot reserved for the national health plan identifier when one is established. 3 lines, one each for primary, secondary and tertiary payers.
52	REL INFO	Release of information certification indicator (Y or I). 3 lines, one each for primary, secondary and tertiary payers.
53	ASG BEN	Assignment of benefits certification indicator. 3 lines, one each for primary, secondary and tertiary payers.
54	PRIOR PAYMENTS	Payments from other payers or patient. 3 lines, one each for primary, secondary and tertiary payers.
55	EST. AMOUNT DUE	Estimated amount due from patient. 3 lines, one each for primary, secondary and tertiary payers.
56	**NPI**	**NPI for billing provider.**
57	OTHER PRV ID	Other provider identifier (non-NPI assigned by Excellus BlueCross BlueShield). 3 lines, one each for primary, secondary and tertiary payers. Do NOT include non-NPI provider number after May 22, 2008.
58	INSURED'S NAME	Name of holder of the insurance contract. 3 lines, one each for primary, secondary and tertiary payers.
59	P REL	Patient's relationship to insured. 3 lines, one each for primary, secondary and tertiary payers.
60	**INSURED'S UNIQUE ID**	**Insured's insurance identification number. 3 lines, one each for primary, secondary and tertiary payers.**

UB-04 CMS-1450 Field Descriptions

See notes at the end of this chart.

Field	Name	Entry
61	GROUP NAME	Insured's group name. 3 lines, one each for primary, secondary and tertiary payers.
62	INSURANCE GROUP NO.	Insured's group number(s), if available. 3 lines, one each for primary, secondary and tertiary payers.
63	TREATMENT AUTHORIZATION CODES	Excellus BlueCross BlueShield authorization number. 3 lines, one each for primary, secondary and tertiary payers.
64	DOCUMENT CONTROL NUMBER	Area for Excellus BlueCross BlueShield to assign claim number
65	EMPLOYER NAME	Insured's employer name. 3 lines, one each for primary, secondary and tertiary payers.
66	**DX**	**Qualifier code reflecting ICD revision. Enter the number "0" to indicate ICD-10 or "9" to indicate ICD-9.**
67	**Label is 67**	**Enter principal diagnosis code. Include all digits (4-5) where applicable.**
67	A through Q	Other diagnosis codes. Include all digits (4-5) where applicable.
68	Unlabeled	2 lines – not used
69	**ADMIT DX**	**Admitting diagnosis code (if inpatient claim)**
70	PATIENT REASON DX	Patient's reason for visit (diagnosis) code(s) (3 blocks)
71	PPS CODE	Prospective Payment System code
72	ECI	External cause of injury code(s) (3 blocks)
73	Unlabeled	Input DRG code here.
74	**PRINCIPAL PROCEDURE CODE and DATE**	**Enter principal procedure code and date of procedure (see current ICD-PCS codes beginning with the 10th Revision)**
74a-e	OTHER PROCEDURE CODE and DATE	As applicable, enter other procedure codes and dates
75	Unlabeled	4 lines - not used
76	ATTENDING – NPI, QUAL, LAST, FIRST	5 boxes. Enter NPI of attending provider and last and first names of attending provider
77	OPERATING – NPI, QUAL, LAST, FIRST	5 boxes. Enter NPI of operating provider and last and first names of operating provider

UB-04 CMS-1450 Field Descriptions

See notes at the end of this chart.

Field	Name	Entry
78	OTHER – NPI, QUAL, LAST, FIRST	5 boxes. Enter NPI of other provider and last and first names of other provider
79	OTHER – NPI, QUAL, LAST, FIRST	Same as above
80	REMARKS	4 lines for notation that doesn't go elsewhere
81	CC	Code-Code (lines a through d, 3 boxes each)
81a	Taxonomy code qualifier and taxonomy code(s)	In first box, enter qualifier code B3 for field 56 billing provider taxonomy code. In second (and third, if applicable) boxes, enter taxonomy code(s) for the field 56 billing provider.
81b	Other code qualifier and other code	As needed
81c	Other code qualifier and other code	As needed
81d	Other code qualifier and other code	As needed

KEY

- Bolded and shaded fields indicates that claim cannot be processed if information in these fields is missing, illegible or invalid. Claim will reject at front end.

Note: ***Excellus BlueCross BlueShield requires information in certain other fields before it can adjudicate the claim. These fields may vary with the type of service being billed. Completion of all fields does not guarantee payment.***

Excellus BlueCross BlueShield Participating Provider Manual

8.0 Quality Improvement

Providers who agree to participate with Excellus BlueCross BlueShield have also agreed to cooperate in and comply with the standards and requirements of Excellus BlueCross BlueShield's quality improvement (and other) initiatives.

8.1 Quality Improvement Program F

Note: To request a copy of the complete *Quality Improvement Program Description*, contact Customer Care. For Excellus BlueCross BlueShield address and contact phone numbers, see the *Contact List* in Section 2 of this manual or access it through the website under the *Patient Care* tab.

8.1.1 Mission

The purpose of the quality improvement program is to support the mission of Excellus BlueCross BlueShield in its efforts to improve the quality of life in the communities that we serve. Excellus BlueCross BlueShield strives to empower members and employers to become active participants in their personal health status through educated, informed decision making. Collaboration with practitioners and providers helps to ensure the rendering of safe, high quality and cost-effective care. The goal of the program is to improve member health through initiatives focusing on chronic disease, patient safety, continuity and coordination of care, and service quality. The success of the program is evidenced by measurable improvements in member health and satisfaction.

8.1.2 Scope and Content

The Quality Improvement Program manages and communicates Plan performance against national industry best practice benchmarks. Additionally, the program addresses issues of quality safety and access to care for commercial, Medicare and Medicaid managed and non-managed care members. The program supports members, providers, practitioners, employers, hospitals and the community, while addressing and integrating all the regulatory and accreditation requirements.

Excellus BlueCross BlueShield's clinical focus is on engaging members with particular health conditions (currently cardiovascular diseases and diabetes) in programs designed to improve their health outcomes. Excellus BlueCross BlueShield provides comprehensive coordination of care with seamless transitions throughout all stages of care from wellness and prevention to end-of-life support.

Excellus BlueCross BlueShield seeks to increase the sense of empowerment for members and/or caregivers through program engagement and education that enhances collaboration with practitioners and providers, thus ensuring improved continuity of care.

Patient safety is a key focus area of the Quality Improvement Program. Practitioners are encouraged to incorporate a patient-specific systematic process into the practice setting, often through adoption of Health Information Technology, to enhance the quality of patient care. Innovative practitioner improvement programs also are utilized to drive quality through collaborative activities with hospitals and/or practitioner practices.

Excellus BlueCross BlueShield's service quality includes a strong focus on ensuring access and availability of quality care for our members across all lines of business. Credentialing and re-credentialing of practitioners and organizational providers helps ensure continued adherence to established care standards. Excellus BlueCross BlueShield assesses and works to improve member satisfaction with practitioners and Excellus BlueCross BlueShield, as well as improving practitioner satisfaction with Excellus BlueCross BlueShield.

Excellus BlueCross BlueShield's community initiatives are collaborative and include partnerships with community practitioners, providers, and agencies to provide quality and comprehensive health care to members in an integrated manner.

8.1.3 Goals and Objectives

- Quality Improvement Program goals and objectives are established annually following review of the previous year's outcomes. The goals and objectives from Excellus BlueCross BlueShield's Quality Improvement Program Description are summarized below.

8.1.4 Quality Improvement Program Goals and Objectives

Opportunities and outcomes of the Quality Improvement (QI) Program are determined by remaining attuned to the processes of all departmental activities that drive member health, safety and experience. Operational, process and health outcome improvements are developed and implemented in support of our program goals. The QI Program framework provides Excellus BlueCross BlueShield with a formal decision-making structure where goals and objectives are identified, work is grouped and coordinated, and progress is tracked and reported. This framework is flexible to allow for ongoing analysis and adjustment for continued progress toward defined outcomes; this allows for adjustments to be made to adapt to the complex and rapidly changing regulatory environment.

Scope of Activities

Excellus BlueCross BlueShield activities included in the scope of the QI Program include, but are not limited to:

- Clinical and service quality measurement, analysis and initiatives
- Patient safety and risk management initiatives
- Behavioral health services
- Physician and hospital quality programs
- Pharmacy management and medication safety programs
- Credentialing and recredentialing
- Utilization management

- Access and availability to health-care services measurement, analysis and interventions
- Continuity and coordination of care
- Disease and complex care management programs
- Non-complex care management programs
- Wellness and employer group activities
- Member self-service initiatives
- Delegation monitoring and oversight
- Privacy and confidentiality activities

2016 Quality Improvement Program Goals

- Focus on coronary artery disease (CAD), heart failure and diabetes
    - Improve member health outcomes through gap closure and medication adherence
    - Improve transitions in care for high-risk members who have chronic conditions
    - Improve member sense of self-empowerment in chronic conditions
- Increase patient safety
- Be a 5 STAR-rated Medicare Advantage Plan
- Meet and exceed external regulatory and accreditation demands
- High level of member and provider experience with Excellus BlueCross BlueShield
- Promote evidence-based medicine while exceeding industry quality measure benchmarks including HEDIS/CAHPS/QARR, NCQA, CMS, NYSDOH indicators

8.1.5 Credentialing and Recredentialing

Credentialing helps ensure the provision of accessible, cost-effective quality care to members, via review of all practitioners and providers who apply to participate with Excellus BlueCross BlueShield's managed care, Medicare Advantage or PPO products. Credentialing occurs prior to participation (initial application) and at regular intervals thereafter (recredentialing/reappointment). The process is an objective evaluation of a person's current licensure, training or experience, competence, and ability to provide particular services to our members in their credentialed specialty. Practitioners are afforded an appeal process in accordance with established policies and procedures, if the Credentialing Committee reduces, suspends, or terminates a practitioner's participation for reasons related to quality of care, competence or professional conduct.

Excellus BlueCross BlueShield delegates the oversight of the credentialing process to the Credentialing Committee. Please see Section 3 of this manual for more information about Excellus BlueCross BlueShield's credentialing and recredentialing process.

8.1.6 Behavioral Health

Excellus BlueCross BlueShield maintains a comprehensive Behavioral Health Program that consistently monitors and evaluates behavioral health care and services for clinical effectiveness and efficiencies, aligning with the corporate mission and goals. Services are assessed for appropriate, medically necessary, effective levels of care, and supportive

resources, and progressive interventions for improvement to ensure high quality care and patient safety. The Behavioral Health Department promotes and facilitates continuity and coordination of care throughout the member's treatment across the health care spectrum. View details about each behavioral health specific quality standards and measures in 6.6 Behavioral Health section of this manual.

8.1.7 Health and Wellness

Excellus BlueCross BlueShield maintains a broad-based Health Promotion Program for members, designed to educate and promote healthy lifestyle choices. Programs and services available to members through the Health Promotion Program include health risk assessments, health improvement programs, the Quit for Life tobacco cessation program, web-based self-help tools, a health information line, the fitness program, health reminders, and worksite wellness programs.

Preventive health is a responsibility shared by all clinical programs and health plan staff. Excellus BlueCross BlueShield has implemented preventative health tools and programs for members across the entire care continuum, seeking to maximize healthy living and disease prevention.

Workplace Wellness (WW)

The WW team is the bridge between health plan and employer groups, seeking to manage employees' health care and related costs through education, analytics, reporting and consultation. This focus ensures that employers are aware of resources and programs available through RFPs, collaboration on development of collateral, and participation in presentations. The WW team staff assists employers with implementation of programs and provides information pertaining to member engagement in the programs with results as available. The programs that WW promotes include, but are not limited to, worksite wellness, health risk assessments, tobacco cessation, disease management, care management, and utilization management.

8.1.8 Disease and Case Management

Excellus BlueCross BlueShield maintains disease and case management programs and services that span the continuum of care from early stage conditions through acute events, severe chronic disease, and death with dignity.

Population-Based Disease Management

The Disease Management Program is a population-based program that helps members who have chronic conditions such as asthma, heart disease, diabetes and depression. Using drug and medical claims in identification and stratification of needs, this program provides education and action-oriented information to help members understand their condition and avoid complications. Preferential, sensitive-condition support through the care management program is available around the clock to Excellus BlueCross BlueShield members with conditions that have multiple acceptable treatment options. High-risk members receive outreach from a care manager.

Case Management

A telephonic, collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Complex Case Management

A telephonic coordination of services for members with multiple or complex conditions that helps them access needed care, services and resources. Complex case management is an opt-out program; all eligible members have the right to participate or to decline to participate, and does not limit eligibility to one complex condition or to members already enrolled in the chronic (DM) program.

Complex case management interventions are driven by an individualized plan of care with prioritized short-term and long-term goals developed in collaboration with the member and his or her physician. The program seeks to provide case-managed members with appropriate resources and assistance to manage their health care across the continuum of care, with the ultimate goal of achieving enhanced quality of life.

8.1.9 Government Programs

The Safety Net Program is responsible for ensuring that Excellus BlueCross BlueShield provides a program that meets the unique needs of the Medicaid Managed Care population that includes Child Health Plus and managed Medicaid members. The Safety Net population has several risk factors, including limited access to health care and socioeconomic status, race, ethnicity and language barriers associated with health disparities. The Safety Net staff provides a robust Quality Improvement Program, as well as community-focused case management, that integrate community agencies in combined management of medical, mental health, substance use and psychosocial issues. In addition to focusing on the preventive measures of mammography, well-child visits and cervical cancer screenings, the health plan also focuses on other critical quality measures that are specific to prenatal and post-partum care and respiratory disorders. **Current Multi-Year Medicaid Quality Program Initiatives:**

- Excellus BlueCross BlueShield strives to ensure that Child/Teen Health Program (C/THP) care and services are provided in sufficient amount, duration and scope to reasonably be expected to produce and maintain a healthier population. Early Periodic Screening Diagnostic and Treatment (EPSDT) screenings are crucial in ensuring that children and adolescents receive appropriate preventive, dental, vision, hearing, mental health, developmental and specialty services that are designed to ensure children and adolescents of all ages receive early detection and preventative care so that health problems may be averted or diagnosed and treated as early as possible. Excellus BlueCross BlueShield will analyze and trend the data year over year to better understand use of these services

- Excellus BlueCross BlueShield requires that practitioners' prenatal medical records be maintained in a manner that is confidential, current, detailed, comprehensive and organized and retrievable by the treating practitioner and the health plan. Medical Record Documentation Standards are established and address the organization and content of the records. The Medicaid Prenatal Care Medical Record Review process that Excellus BlueCross BlueShield supports is designed to assess and support practitioners' compliance with the New York State Department of Health Medicaid Prenatal Care Standards. A sample of medical records is evaluated on an annual basis. There is a follow-up letter sent to participating providers regarding the results of the prenatal medical record review.

- Increase the measurement, reporting and improvement initiatives associated with preventable events such as Preventive Quality Indicators (PQI), Potentially Preventable Readmissions (PRPs) and Emergency Department use for Preventive Care (PPVs)

- Increase awareness of behavioral health measurements by developing and implementing a more robust tracking and reporting mechanism and incorporating expanded populations, such as Health Homes in the Quality Assurance Reporting Requirements (QARR) measurement.

The Medicaid Manager of Quality Programs can be contacted at 1-585-238-4581.

Medicare

Medicare Advantage

Along with activities that are part of the comprehensive Member Care Management program, there are numerous initiatives that are geared toward the Medicare Advantage membership. These programs specifically target individuals over age 65 facing experiences that are common in an aging population. Initiatives will be put in place in conjunction with other internal areas, such as Member Care Management, Excellus BlueCross BlueShield Pharmacy Management and Marketing, as well as vendor support. Interventions will focus on the following areas and are likely to become multi-year programs:

- Cardiovascular disease with a focus on blood pressure
- Diabetes treatment
- Diabetes care—blood sugar control
- Plan to reduce all cause readmissions
- Osteoporosis management
- Improving, maintaining, and monitoring physical activity
- Enrollment timeliness
- Grievances and appeals

There are also specific projects/programs:

- Reducing the rate of readmissions is the current three (3) year initiative for the CMS Quality Improvement Project. The program plan was approved by CMS on December 19, 2012. The intervention targets members who are at risk for readmission. Excellus BlueCross BlueShield will reach out and invite the members to participate in a Member Care Management (MCM) program. MCM reviews and mitigates risks associated with transitions of care.
- The CMS five (5) year Chronic Care Improvement Program (CCIP) focuses on reducing cardiovascular disease, with an emphasis on preventing heart attacks and strokes. The program plan was approved December 20, 2012. Since cardiovascular disease increases with age, the Medicare population was identified for this program. The focus of the intervention is on controlled/normal blood pressure, as well as provider and member education.

Excellus BlueCross BlueShield will continue to promote provider education, and provide tools and guidelines. Excellus BlueCross BlueShield will continue to provide members with information on healthy behaviors in addition to including them in member care management programs based on their needs.

8.1.10 Community Focus

The Corporate Quality Improvement Program supports Excellus BlueCross BlueShield's mission to improve the health of the community.

Focus on Physical Activity and Nutrition

The Health Promotion and Worksite Wellness Programs support the Community and Member Health Improvement Council (CAMHIC) in its efforts to increase awareness of the importance of physical activity and nutrition.

Focus on Chronic Conditions

Member and provider programs focus on chronic conditions from a community, population, employer and member perspective. Care management systems are utilized to help identify members who may be in need of education and/or care coordination. Evidence-based clinical practice guidelines assist practitioners in the management of chronic conditions. Provider and hospital incentive programs are often structured to assist in the medical management of members with chronic conditions. Excellus BlueCross BlueShield Pharmacy Management focuses on improving pharmaceutical management of chronic conditions.

Focus on Access to Care for the Underserved Population

Excellus BlueCross BlueShield's Government Programs target the underserved population with multipronged interventions to improve the health outcomes for Medicare and Medicaid members.

Focus on Patient Safety

Excellus BlueCross BlueShield's member and provider programs support patient safety, as do the accreditation and regulatory processes. Excellus BlueCross BlueShield Pharmacy

Management has created several important pharmacy management programs, to maintain patient safety in the area of pharmaceutical utilization.

8.1.11 Provider Quality and Performance Improvement

Built upon the core principles of the triple aim - improve health care quality, lower costs and enhance the patient experience – Provider Performance Improvement (PPI) Programs support the creation of a high performance network to improve the overall quality of care provided to our members and the communities we serve.

As the health plan continues to support our provider partners in all sectors of healthcare, we strive to provide programs and venues that help decrease fragmentation, improve care coordination and allow for collaboration in comprehensive patient-centered care with higher quality and lower costs.

Physicians and hospital are directly supported by our PPI consultant team of licensed RNs, MBAs, Certified Professional Coders, experts in population health management, quality improvement specialists, Patient Centered Medical Home (PCMH) Certified Consultants, health care administrators, Certified Case Managers, Lean Six Sigma professionals and experienced data analysts, all who have multi-specialty expertise and experience that makes them uniquely qualified to support our provider partners through comprehensive clinical quality improvement.

Partnering to Achieve Quality (PAQ) – Provider Consulting Services

PPI Consulting Services are designed to drive improvement in population health, including preventive health, acute and chronic disease care, and patient safety through application of system level processes and delivery of patient-centered care. Hierarchical in nature, based on ability and/or tolerance for financial risk, the programs are built using a consistent framework for determining quality performance using established and tested measures that align with national measure sets with level of risk being the primary variable. These programs support providers in their efforts to improve patient safety outcomes while improving fiscal performance through means other than increases in payment rates.

The PPI Consultants provide additional ad hoc support to hospital quality teams and physician practices through targeted and focused interventions as opportunities are identified through accreditation and regulatory program activities as well as through the Practice Facilitation Program, described below.

Clinical Transformation Facilitation Program

The Practice Facilitation Program seeks to provide the best resources available to support the ever changing landscape of health care delivery.

The program combines many proven delivery strategies that are customized to meet the needs of the practitioner. Elements from different categories can be combined to create a program unique to the learning needs of the practice. Some category topics are:

- Readiness Assessment
- Practice Redesign
- Patient Management
- Population Management
- QI and Measurement/Model for Improvement
- Certification/Recognition Programs
- Coding Tips

Provider Performance Improvement (PPI) nurse consultants, who have all received NCQA PCMH Content Expert Certification, and Coding Certification work with our provider partners, helping them assess and understand their operational issues; develop customized strategies for change; define measurable outcomes; and establish processes to sustain these improvements. Nurse Consultants provide tools that support/coach provider practices toward gaining the skills and knowledge necessary to implement a patient-centered model of care.

Accountable Cost and Quality Arrangement (ACQA)

Accountable Cost and Quality Agreements (ACQA) are innovative payment programs designed to drive improvements in patient experience, cost trends, and quality of care. Similar to an Accountable Care Organization (ACO), the programs establish a new relationship between the health plan and partner integrated healthcare systems or large primary care physician groups based on healthcare quality and financial gain share. ACQA, administered with the integrated healthcare systems, is a full innovative payment program with both upside and downside risk. Savings generated by exceeding the budget target is shared with the system based on overall quality performance. Should financial performance result in a loss, the proportion of the loss passed to the system is moderated by the overall quality performance score.

ACQA encourages providers to balance need of care with cost of care, emphasizes chronic illness management, patient safety and preventive care, and helps control cost of medical trend while at the same time driving improvement in quality health outcomes. ACQA promotes a more collaborative, higher quality, local health care system where care is better coordinated, helping eliminate unnecessary expenditures. Primary care physicians are encouraged to take a more active role in population health and are afforded better understanding of patient needs via advanced, predictive modeling technology provided by the Health Plan. The ACQA program provides a measurable way to track quality and savings performance by incorporating measures that are developed from accredited institutions, including the National Quality Forum (NQF) and the National Committee for Quality Assurance (NCQA).

Clinical measure performance rates for ACQA are calculated using data reports generated from the health plan's selected performance measurement vendor, Arcadia Healthcare Solutions. Practices are expected to utilize the vendor performance reports to monitor practice aggregate and physician level measure performance and implement improvement interventions.

Rewarding Physician Excellence (RPE)

The RPE Program is a performance improvement incentive program for primary care physicians. This program is designed to introduce practices to both quality and cost improvements through a focus on both high quality and efficiency performance. The program also serves as a foundational step in a hierarchal portfolio of innovative payment programs and is set up as a foundation for seamless transition into more robust ACQA arrangements.

Physicians who achieve established performance goals for quality, efficiency, and operational measures can earn a Quality-Efficiency Bonus paid through a fee schedule enhancement.

Clinical measure performance rates for RPE are calculated using data reports generated from the health plan's selected performance measurement vendor, Arcadia Healthcare Solutions. Practices are expected to utilize the vendor performance reports to monitor practice aggregate and physician level measure performance and implement improvement interventions.

Hospital Performance Incentive Program (HPIP)/Small Hospital Incentive Program (SHIP)

This pay for performance program is rolled out as hospital contracts open for negotiation. The menu-driven incentive program utilizes all payer data, rather than only Plan membership, for measurement and applies it to all lines of business contracted with the hospital. The program exists best as a component of multi-year agreements and models a prospective payment methodology. Annual performance targets using nationally recognized measures are established to define expectations for improved performance, and if the hospital achieves the target outcomes agreed upon jointly, the negotiated extra payment for quality applies the following year.
These programs focus on improving outcomes in four care dimensions:

- Clinical: Includes required measurement in hospital acquired infection measures
- Patient Safety: Includes required measurement in hospital readmissions
- Patient's Perception of Care/Satisfaction: Incorporates a hospital's use of a national patient satisfaction survey such as Press Ganey and/or the H-CAHPS patient satisfaction tool
- Custom: Allows for participation in high impact and/or Health Information Technology-related performance improvement activities

Pediatric Quality Incentive Program (PQIP)

Getting patients in for a well care visit (WCV) is the primary focus for the Pediatric Quality Incentive Program. Recognizing that the majority of preventive recommendations are provided during the well care visit, encouraging completion of all age appropriate screenings at the well care visit is the subsequent focus of the program. Providers are given a list of patients who are either overdue for a WCV or who are coming due within the next 90 days. Providers are requested to schedule and complete the WCV providing all necessary preventive screenings, counseling, lab work, and immunizations as appropriate. Incentive reward is earned for completing the comprehensive WCV defined as the visit and all age appropriate specified preventive care services.

The PQIP program is administered to provider groups with high volumes of the Safety Net population.
This program is currently closed pending re-development into a new program for 2017.

Partnering to Achieve Quality (PAQ): Provider Quality Improvement Programs

Provider quality improvement programs are designed to support our corporate mission to provide access to affordable health care and improve the health of the members and communities we serve. These programs help us do this by improving patient safety outcomes, helping providers improve fiscal performance through means other than increases in payment rates, providing assistive funding for participation in health plan sponsored, focused quality programs, and supporting collaboration with providers, moving from individual inpatient and outpatient focus to regional Collaboratives that generate network-wide data driven results. At this time we have four Collaboratives that include various types of programs provided by vendors and three Networking Alliances.

PPI Collaboratives

The Health Plan's Provider Quality Improvement programs are unique and innovative, as no other health plan in upstate NY has invested in programs of this type. These programs can be used by regional leadership to support collaborative activities and build significant relationships. Joint planning occurs to determine which program offering best fits with a hospital's strategy to improve overall quality and cost. Health Plan provides supportive funding to providers when they join a collaborative; amount varies by program. The programs are viewed as employer/Health Plan investments that seek to align and integrate performance improvement programs with the goals of generating return on investment, impacting affordability, and improving quality of care for the communities served. Availability of these programs has become generally known in the provider community and important linkages have also resulted with the HPIP/SHIP program, further supporting these initiatives by focusing improvement efforts on the

reduction of hospital-acquired infections, surgical complications, and other adverse patient safety events.

Current Provider Quality Improvement Collaboratives include:

- **Upstate NY Hospital Quality Initiative (UNYHQI)** – Excellus established a pilot program to reduce hospital-acquired infections in seven upstate New York hospitals in late 2005, titled the Upstate New York Hospital Quality Initiative (UNYHQI), provided by CareFusion/MedMined Services. This pilot experience has shown a reduced number of infections resulting in better patient outcomes, reduced exposure to unnecessary medical tests, reduced lengths of stay, and lowered costs.

    - Participating hospitals have experienced a meaningful reduction in the number of infections acquired, The comprehensive model continues to facilitate a proactive approach to infection prevention, and it is achieving the collaborative goal of reducing hospital-acquired infections.

- **Upstate NY Surgical Quality Initiative (UNYSQI): National Surgical Quality Improvement Program (NSQIP) Collaborative** - The American College of Surgeons' (ACS) National Surgical Quality Improvement Project (NSQIP) is a nationally, validated, risk-adjusted, outcomes-based program that measures and improves the quality of surgical care, with the goal of improving surgical outcomes and reduce the costs associated with them. 18 hospitals across upstate New York are currently participating.

    - Since the program's inception, the UNYSQI participants have made notable improvements in surgical care. The 30-day post-operative complication/morbidity rate results are 58% below the expected rate. The reduction in total aggregate complications represents an estimated 431 avoided surgical complications, saving the hospitals approximately $23.3 million through 2014. (1)

- **Bordering on Zero (BOZ)** – Began as a 3-year collaborative with network hospitals using "Liberating Structures" as a means to engage and empower front-line hospital staff in driving improvements in patient safety among 13 hospitals in the Central New York, Utica, and Southern Tier regions. Liberating Structures are simple, low cost, quick-to-implement methods that liberate workforce energy by helping change how teams interact, enable creative problem solving, and drive sustainable change.

  Results to date reveal meaningful improvements in the reduction of falls, urinary tract infections, central-line associated bloodstream infections, surgical site infections, and improved hand hygiene.

BOZ will continue an additional 18 months beginning in the fall of 2015 for five key hospital partners who have seen positive results and requested our support in continuing the program.

- **Rochester Infection Prevention Collaborative** – Established in 2008 this group of hospitals focuses on the reduction of healthcare associated infections (HAIs) as a community. They drove reduction of central line infections outside the ICU by 50% and were then asked to tackle C-Difficile due to the significant burden and cost of this infection locally, and the potential to reduce the burden of the disease using enhanced infection control measures. This group actively led the charge and has successfully exceeded their goal of a 30% reduction in C-Difficile infections in hospitals, long term care facilities and the community within the first three years.

    - The significant success of this group and the impact C-Difficile makes on all of the communities we serve has resulted in an expansion of the program to include additional regional focus groups in 2016.

PPI Alliances

Started in response to our provider partners' requests for such forums, Provider Alliances provide a venue where they are able to share best practices, learn from community subject matter experts in the quality field, exchange information related to common or uncommon concerns, network with each other, and build trusting relationships. The Alliances meet throughout the year in varied locations in order to allow for network-wide participation and topics covered are determined mutually by participating providers and the Health Plan.

The Health Plan has earned a reputation as an effective supporter of provider performance, quality improvement and patient safety. The Alliances are facilitated by the Health Plan to provide an ongoing forum for all provider quality professionals to discuss the ever-changing healthcare environment and the difficulties being faced by providers in establishing strategies to deal with these challenges. They provide members an opportunity to network and build relationships for the purpose of building a collaborative approach for providers and Health Plan to continue improving patient safety and clinical quality outcomes over time.

Current Provider Alliances include:

- **Hospital Quality Alliance (HQA)** – supporting in-patient quality improvement
- **Primary Care Quality Alliance (PCQA)** – supporting out-patient quality improvement
- **Health System Alliance (HSA)** – supporting coordination of an effective "Medical Neighborhood"

BlueCross BlueShield – Blue Distinction

Blue Distinction offers a suite of flexible national solutions that make it easier for Blue Plans to design benefits tailored to employers' specific needs via designated providers that have met nationally consistent criteria for quality and cost.

Blue Distinction® is evolving into a program based on Total Value, which includes a balance of quality, cost, and access:

Quality

- Establish a nationally consistent and continually evolving approach to evaluating quality and safety by incorporating quality measures with meaningful impact, including delivery system features and specific quality outcomes to which all can aspire.

Cost

- Establish a nationally consistent, equitable, and objective approach for selecting Blue Distinction Centers that address market and consumer demand for cost savings and affordable healthcare.

Access

- Accommodate consumer access to Blue Distinction Centers while achieving its overall goal of providing differentiated performance on quality and cost of care.

Two levels of distinction available for specialty care:

Blue Distinction Centers (BDC)

- Meet overall quality measures for patient safety and outcomes, developed with input from the medical community.

Blue Distinction Centers+ (BDC+)

- Meet all of the same quality standards as Blue Distinction Centers, while also demonstrating a lower cost of care relative to non-Blue Distinction Center+ designated facilities.

BDC available in seven specialty care areas:

- Bariatric Surgery – Banding & Stapling
- Cardiac Care
- Complex and Rare Cancers
- Knee and Hip Replacement
- Spine Surgery
- Transplants
- Maternity Care

8.1.12 Monitoring and Surveillance

Practitioner Performance through Medical Record Review

Annually, Excellus BlueCross BlueShield selects a sample of PCP offices to review for medical record documentation against established standards. (See paragraph entitled *Medical Record Documentation Standards* later in this section.) As part of the medical record review process, results are outlined and forwarded to the practitioner. Practitioners with results below the established compliance threshold are required to submit a corrective action plan within 30 days for identified deficiencies. Re-audits are conducted in six to 12 months to ensure that the corrective action plan has been implemented. Annually, aggregate reports of compliance with the standards are presented to the Healthcare Quality Monitoring Committee to identify opportunities for improvement. Actions, interventions and follow-up are implemented based on the results of the annual review.

Ongoing Monitoring of Practitioner Performance

Excellus BlueCross BlueShield is committed to providing members with access to quality services. As part of our efforts to improve quality, we conduct performance reporting, which includes medical/treatment record (*see 8.2 Medical Records*) and clinical quality reviews; analyzing complaints and grievances, satisfaction data and appointment assessment (*see 8.3 Appointment Availability Standards)*. Practitioners are compared against an appropriate group of practitioners serving a comparable patient population. The criteria used for these reviews may be found within this manual and/or at ExcellusBCBS.com/ProviderPatient Care. The results of these activities are shared with the Healthcare Quality Monitoring Committee and as they become available. Excellus BlueCross BlueShield has a process to identify and, when appropriate, refer results from these activities to the medical director. This includes, but is not limited to, cases requiring action related to quality and safety issues. Practitioners are provided feedback from performance reporting, and upon request, from the practitioner.

If any monitoring data leads to trends being identified, a health plan medical director will contact the practitioner to discuss the specific practitioner monitoring report findings and assist with identifying opportunities for improvement and plans to improve performance. The practitioner will be given the opportunity to discuss the unique nature of the practitioner's patient population, which may have a bearing on the outcome of these reports. In some cases, the recommendations are forwarded to the Credentialing Committee for consideration. Information also is reviewed at the time of recredentialing.

Continuity and Coordination of Care

The continuity and coordination of care that members receive is monitored across the health care delivery system. At least annually, Excellus BlueCross BlueShield identifies areas for improvement across medical settings or transitions in care. Targeted activities are implemented to address the identified opportunity. Data collection, analysis and re-measurement are completed for each improvement opportunity.

Clinical Quality

The Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) are used by more than 90 percent of America's health plans to measure performance across the most pressing clinical areas, as well as dimensions of patient satisfaction and experience. Additionally, the Quality Assurance Reporting Requirements (QARR) are specific measures added to address public health issues of particular importance in New York state and are required by the New York State Department of Health. HEDIS/CAHPS and QARR data collection are completed annually and provide a mechanism for Excellus BlueCross BlueShield to identify areas of opportunity and work on improvements.

Facility Monitoring

Excellus BlueCross BlueShield monitors hospitals through a number of initiatives, including the HPIP and HQIP programs and the Hospital Performance Report mentioned in section 8.1.11.

Member Complaints, Grievances and Appeals

Excellus BlueCross BlueShield maintains a process to address member complaints (informal expression of concern), grievances (formal complaint) and appeals. The Healthcare Quality Monitoring Committee reviews complaint and grievance/appeal reports on a regular basis to identify trends of dissatisfaction. These reports may be used as the basis for service improvement activities and, if appropriate, for evaluating the effectiveness of interventions. Member complaints regarding providers are included in the Provider Monitoring Report when trending is identified.

Access and Availability

Excellus BlueCross BlueShield maintains appointment availability standards and monitors according to the standards to ensure members have access to care. Provider/member ratio standards and geographic access standards also are maintained and monitored regularly.

Member Cultural Needs and Preferences

Excellus BlueCross BlueShield annually assesses member needs by reviewing Plan demographic data and provider availability for members who have preferred needs, such as availability of Spanish-speaking physicians for Hispanic members, or needs based on requests for language interpreters. The Healthcare Quality Monitoring Committee reviews this information annually and develops action plans as needed.

8.1.13 Patient Safety

Patient safety is addressed through multi-pronged interventions, activities, collaborative efforts and oversight. Excellus BlueCross BlueShield monitors the safety of care provided to members in inpatient and outpatient settings and implements interventions or programs as deemed appropriate. In addition, Excellus BlueCross BlueShield promotes safe medication

use and consultation programs that are designed to promote safe, effective and appropriate drug therapy.

Blue Distinction Programs

Excellus BlueCross BlueShield participates in a program administered by the BlueCross BlueShield Association known as Blue Distinction and Blue Distinction +. Hospital programs have been established for bariatric surgery, cardiac care, transplants, spine surgery, hip/knee surgery, and complex and rare cancers. Recently, Blue Distinction has evolved to become a value-based designation awarded to hospitals that meet stringent quality and cost criteria. Blue Distinction also is focused on patient safety and outcomes, developed with thoughtful input from the medical community as well as cost of care measures that address consumers' need for affordable health care. Its goal is to help consumers find both quality and value for their specialty care needs on a consistent basis, while encouraging health care professionals to improve the overall quality and delivery of care nationwide.

Hospital Comparison Tool

Since 2003, Excellus BlueCross BlueShield has provided a Web-based hospital comparison tool allowing providers and members to compare hospital performance across numerous procedures and medical conditions.

Never Events Monitoring

In 2010, Excellus BlueCross BlueShield implemented a Never Events/Serious Adverse Events (SAE) policy. An SAE includes (i.) an extremely rare medical error that occurs in a hospital (inpatient or outpatient),outpatient setting, ambulatory surgery center or provider office and should never happen to a patient, and (ii.) other events that should never happen to a patient ("never events"). The Hospital Performance Improvement department performs quarterly audits to identify any patterns in SAE occurrences and collaborates with the Analysis and Recovery department to identify payment recoupment opportunities. In instances where Excellus BlueCross BlueShield has already paid for a claim involving an SAE, Excellus BlueCross BlueShield may recoup such payments. In addition, tracking and trending is performed on a hospital basis to compare hospital performance across numerous SAEs. In some situations, outreach to QM and/or medical leadership is necessary in order to assure ongoing collaboration and to establish a hospital quality plan of action as warranted.

Office Site Visits/Complaint Investigation

Excellus BlueCross BlueShield will investigate complaints from any source regarding deficiencies in the physical site of the practice for all credentialed practitioners. The threshold for conducting a site visit is two (2) formal or informal complaints from members within 12 months.

Point of Sale Pharmacy Edits

Drug Use Management programs are implemented to ensure members receive clinically appropriate and medically necessary prescription drugs. The programs are developed to ensure prescription drugs are filled safely according to the drugs' FDA-approved indications

at the point of sale (POS). Edits and messages to pharmacists at POS alerting them of Drug Utilization Review (DUR) issues have been built into the claims management system.

High Risk Medication (HRM) Use in the Elderly Program

The Centers for Medicare & Medicaid Services (CMS) reviews health plan, provider level and member level use of High Risk Medications (HRM) in the elderly. The medications included in this review are taken from the Beers criteria for Potentially Inappropriate Medication Use in Older Adults. Excellus BlueCross BlueShield data is reviewed through monthly Acumen reports. Letters may be sent to providers with a list of members on a particular medication along with the reason for the notification. Providers are encouraged to review the information and to make changes as clinically appropriate. Member notification may occur as well. In addition, Excellus BlueCross BlueShield implements utilization management edits (prior authorization, quantity limits or non-formulary placement) to ensure appropriate prescribing.

FDA Drug Recall and Alert Notification

Ensuring that members are not taking medications that have been identified as having harmful interactions is critical to patient safety. To ensure that members are made aware of these risks, Excellus BlueCross BlueShield notifies members and/or prescribing practitioners upon receipt of a significant FDA drug recall or alert. When the members are informed of the alerts, they are encouraged to work with their practitioner to choose a safer medication. In the case of drug recalls, Excellus BlueCross BlueShield explains the safety issue and suggests alternatives to both the member and practitioner.

Collaborative efforts within the community also are undertaken to build health systems that reduce medical errors and enhance patient safety.

8.2 Medical Records

Excellus BlueCross BlueShield requires that participating provider medical records are kept in a manner that is confidential, current, comprehensive, organized and retrievable by the treating practitioner and Excellus BlueCross BlueShield; and comply with all state and federal laws and regulations. A separate medical record must be maintained for each patient and the medical record should verify that the patient's primary care physician coordinates and manages care. For prenatal care only, a centralized medical record should be maintained for the provision of prenatal care and all other services.

The treating provider must retain medical records for at least six years after the date of service. For treatment of a minor, medical records must be maintained for three years after the age of majority or six years after the date of the date of service, whichever is later. For Medicare Advantage, the treating provider must retain medical records for at least ten years after the end of the contract.

8.2.1 Medical Record Review

Participating provider agreements require that providers allow for medical record access / retrieval for clinical encounter data collection programs which are part of 'health care operations' and without cost to the Health Plan. This can be done by on-site office visits, uploading records to a portal, faxing to a secure line or mailing records. The Health Insurance Portability and Accountability Act (HIPAA) provides regulations that describes circumstances in which the Health Plan is permitted to use and disclose Personal Health Information (PHI) for certain activities without first obtaining individuals consent for authorization: including for treatment, payment and for health care operations such as the following:

- Conducting quality assessment and improvement activities such as the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)
- New York State's Quality Assurance and Reporting Requirements (QARR)
- Centers for Medicare & Medicaid Services (CMS) reporting requirements
- Ad hoc activities that comply with HIPAA requirements

Excellus Blue Cross Blue Shield Quality Measurement staff or other departmental staff collects data annually to support these activities and reports its rates to the respective oversight agencies as required. For additional information about HIPAA, see section 2 of this handbook.

8.2.2 Medical Record Documentation Standards

Excellus BlueCross BlueShield has established Medical Record Documentation Standards. Excellus BlueCross BlueShield ~~regularly~~ conducts medical record reviews at offices of primary care physicians (PCPs)* to assess compliance with these standards. The performance goal for meeting medical record documentation standards is 80 percent. This documentation standard is solely for quality purposes and in no way is intended to diminish the documentation responsibilities imposed by law and regulations.

*Excellus BlueCross BlueShield considers the following to be primary care physicians: internal medicine practitioners, family practitioners, general practitioners and pediatricians.

Excellus BlueCross BlueShield's medical record documentation standards pertain to assessment, treatment, health promotion, and patient safety, and are designed to facilitate confidential coordination and continuity of care over time. Excellus BlueCross BlueShield's medical record documentation standards are available on ExcellusBCBS/ProviderPatientCare

Excellus BlueCross BlueShield also requires that medical records be kept confidential. This is checked during on-site reviews for credentialing as well as during the medical record review described below.

8.2.3 Medical Record Documentation Standards Review

Representatives of Excellus BlueCross BlueShield's Quality Measurement (QM) department conduct medical record reviews for selected primary care physicians (PCPs). Reviewers assess performance based on the medical record documentation standards cited above. The process is as follows:

1. A sample of physicians meeting eligibility criteria is selected for review,
2. Records are reviewed for each physician selected,
3. Excellus BlueCross BlueShield sends the physician a letter outlining the results of the review. A provider who scores less than the performance goal of 80 percent will be asked to submit a corrective action plan (CAP) within 30 days. Subsequently, Excellus BlueCross BlueShield conducts another medical record review.

For more information about medical record review, contact the Quality Measurement Department. (For Excellus BlueCross BlueShield phone numbers and addresses, see the *Contact List* in Section 2 of this manual.)

8.2.4 Medicaid Prenatal Care Medical Record Review

The Medicaid Prenatal Care Medical Record Review process is designed to assess the practitioner's compliance with the NYS Medicaid Prenatal Care Standards. These standards reflect comprehensive, high quality, prenatal and postpartum care elements that every Medicaid pregnant women should be receiving. A random sample of medical records is assessed on an annual basis.

The process is as follows:

1. Quality Management (QM) staff, Medical Director(s) and participating provider(s) develop medical record standards. Standards are based on current medical practice guidelines and reflect requirements put forth by regulatory and accrediting bodies.

2. A minimum sample of twenty records (10 per practice) with the practice being rotated every two years, are reviewed annually for Medicaid members who delivered a live birth in the twelve months prior to the review period.

3. Comprehensive obstetrical medical records are requested from practitioners and reviewed by a Quality Measurement Clinical Quality Coordinator at Excellus BlueCross BlueShield.
4. Aggregate data of the medical record outcomes are reported to the Healthcare Quality Monitoring Committee annually

8.2.5 Advance Care Directives

Excellus BlueCross BlueShield encourages providers to discuss with members end-of-life care and the appointment of an agent to assume the responsibility of making health care decisions when the member is unable to do so.

Excellus BlueCross BlueShield's medical records documentation standards state that medical charts must include documentation indicating that adults age 18 years and older, emancipated minors, and minors with children were given information regarding advance directives. A copy of the member's health care proxy, living will, or DNR order should also be included in the medical record, as available.
Excellus BlueCross BlueShield makes advance care directive information and forms available to providers and members through:

- Excellus BlueCross BlueShield's website. *Select For Your Health* from the Member page and Advance Care Planning under QuickLinks at the left.
- Customer Care. Practitioners may request free copies of an advance directive planning booklet by calling Customer Care. (For phone numbers, see the Contact List in Section 2 of this manual.)

  Note: Treatment decisions cannot be conditioned on the execution of advance directives.

8.3 Appointment Availability Standards

Excellus BlueCross BlueShield has established appointment availability standards to provide reasonable patient access to care. These standards are available from Excellus BlueCross BlueShield website ExcellusBCBS/comProviderPatientCare or by calling Customer Care. Practitioners are advised that New York state standards allow visits with nurse practitioners and physician assistants to be counted toward appointment availability compliance.

8.3.1 Coverage Arrangements

Physicians who participate in Excellus BlueCross BlueShield's managed care programs are required to advise Excellus BlueCross BlueShield in writing of covering participating physician arrangements or changes to those arrangements, including situations in which physicians in the same office are covering for each other. To notify Excellus BlueCross BlueShield of a change in coverage, physicians should update their *Practitioner Demographics Form* (described in Section 2 of this manual) and submit it to Excellus BlueCross BlueShield. Physicians should also communicate coverage arrangements to their patients.

8.3.2 After-Hours Care

PCPs and Specialists

When acting as a primary care physician or specialist physician, the physician must make all necessary arrangements with other network physicians to assure the availability of covered services to members of managed care benefit packages 24 hours a day, 7 days a week, including periods after normal business hours, on weekends, or when the physician is

otherwise unavailable. It is understood that the physician will refer managed care members only to other network physicians, except in cases of an emergency or when no network physician is reasonably available. In the latter case, prior authorization from Excellus BlueCross BlueShield's Medical Director is required.

Acceptable Methods of After-Hours Coverage

Excellus BlueCross BlueShield has determined what constitutes acceptable versus unacceptable methods of after-hours coverage.
Excellus BlueCross BlueShield members with medical problems must be able to:

- Reach the practitioner or a person with the ability to patch the call through to the practitioner (i.e., answering service); or
- Reach an answering machine with instructions that result in the ability to contact the practitioner or his/her backup (i.e., message with number for home, cell phone or beeper); or
- Leave a message that is automatically forwarded to the physician's beeper or cell phone. This option is compliant only if the recording explains to the patient how his/her message will be handled.

8.3.3 After-Hours/Urgent-Care Centers

With after-hours or urgent-care centers, patients who have minor injuries or illnesses can get the care they need and avoid time-consuming and expensive visits to the emergency room. These centers specialize in treating minor illnesses or injuries after primary care physician offices have closed for the day. Examples of minor injuries or illnesses include cuts, sprains, simple fractures, flu-like symptoms, earaches, fever and minor burns. A member who thinks he/she may need urgent care should first call his/her primary care physician to be sure the after-hours or urgent-care centers are the right place to go for treatment of his/her condition. Providers may view a complete list of after-hours/urgent-care centers on Excellus BlueCross BlueShield's website.

8.4 NYSDOH Requirements for HIV Counseling and Testing, and Care of HIV Positive Individuals F

Early identification of Human Immunodeficiency Virus (HIV) infection and entry into care can help HIV-infected persons live longer, healthier lives. In addition, identifying infection leads to education, which can help prevent spread of the disease.

The New York State Department of Health (NYSDOH) has HIV counseling, testing, and reporting requirements, along with guidelines to help increase HIV testing, ensure entry into care, and increase laboratory reporting.

An HIV test is the only way to determine whether a person has HIV, and the decision to have an HIV test is voluntary. In order to have an HIV test in New York state, the patient must give consent either orally or in writing.

All practitioners and providers must comply with the HIV confidentiality provisions of Section 2782 of the New York Public Health Law to assure the confidentiality of HIV-related information. Compliance requires:

- Initial and annual in-service education of staff and contractors
- Identification of staff allowed access to HIV-related information and the limits of access
- Procedure to limit access to trained staff, including contractors
- Protocol for secure storage, including electronic storage
- Procedures for handling requests for HIV-related information; and
- Protocols to protect from discrimination persons with or suspected of having HIV infection.

8.4.1 Routine HIV Testing in Medical Settings

The NYSDOH recommends that HIV testing be a routine part of medical care and other services. Recent data indicate that routine HIV testing may be cost effective, even in areas with seroprevalence lower than 1 percent.

Health care providers in New York state are encouraged to discuss HIV with their patients routinely, regardless of their perceived risk, and to have a low threshold for recommending HIV testing since not all infected persons are aware of or willing to disclose their risk.

Health care providers should recommend HIV testing, as appropriate, to all sexually active persons, persons with a history of substance abuse and persons in areas with seroprevalence of 1 percent or lower, including major urban areas.

Health care providers in New York state are required to offer all patients between 13 and 64 years of age a voluntary HIV test.

8.4.2 Informed Consent and Notification for HIV Counseling and Testing

To reduce barriers to HIV testing, the NYSDOH has published the *Informed Consent to Perform HIV Testing* form, available on the DOH website at health.ny.gov/diseases/aids/providers/forms/index.htm. All providers of HIV counseling and testing should utilize this form, or a comparable version approved by the DOH. The form contains all of the basic information that someone would need to know to make a decision about being tested. It is written in simple, easy-to-follow language. For many persons, this written document can be provided for review and, unless there are questions or other circumstances warranting further steps, individuals can be asked to provide oral or written consent. The patient should be encouraged to keep the informational section. The provider should retain the signature page of the *Informed Consent* form.

The *Informed Consent* form also includes authorization for HIV antibody testing and, if HIV-positive, the series of resistance testing and viral load testing, as well as incidence testing to monitor the HIV epidemic. It also allows pregnant women to consent to more than one test during the same pregnancy.

To reduce barriers to HIV testing, written informed consent is no longer required to order an HIV-related test (other than in a correctional facility). Oral consent is permitted, and notification must be provided to the individual being tested, or if the individual lacks capacity to consent, to the person lawfully authorized to consent to health care for such individual. HIV testing providers must inform patients prior to conducting an HIV-related test and must document every HIV test in the patient medical record. Patients may decline an HIV test. Consent is durable until revoked.

8.4.3 Universal Recommendation for Testing of Pregnant Women

HIV counseling and recommendation of testing is indicated for all women in prenatal care without regard to risk. The NYSDOH recommends that HIV counseling and testing be provided early in pregnancy, preferably at the first prenatal visit, to ensure that women who test positive receive appropriate health care, as well as therapy to reduce the risk of mother-to-child HIV transmission. Additional information regarding HIV testing during pregnancy and at delivery can be found at hivguidelines.org

8.4.4 Repeat Testing in the Third Trimester of Pregnancy

Third trimester HIV testing is indicated in the 34th-36th week of gestation. Recent studies have shown that infection during pregnancy, after an initial negative test early in pregnancy, is a leading cause of residual mother-to-child HIV transmission. The *Informed Consent* form has been changed to allow pregnant women to consent once for two tests during pregnancy.

8.4.5 Rapid Test Technology

Rapid HIV antibody tests that can provide a preliminary* result during a single appointment are an important means for providing access to HIV testing, especially in community-based settings. Individuals may be more likely to be tested for HIV if they know that the appointment will be relatively brief.

*Further testing is always required to confirm a reactive (preliminary positive) screening test result.

Additional information about rapid testing is available at the DOH website at health.ny.gov/diseases/aids/providers/testing/index.htm

8.4.6 NYSDOH AIDS Institute Counseling and Testing Resources

Numbers to call for HIV information, referrals or information on how to obtain a free HIV test without having to give the client's name and without waiting for an appointment are listed in the *Informed Consent* form. Upstate New York numbers are also listed below:

- Albany 1-800-962-5065 Rochester 1-800-962-5063
- Buffalo 1-800-962-5064 Syracuse 1-800-562-9423

Special initiatives are available to providers who wish to arrange for a program presentation or possible anonymous HIV counseling and testing at their sites. Providers should contact

the regional coordinator of the Anonymous HIV Counseling and Testing Program at the appropriate toll free number listed above.

NYSDOH AIDS Institute Resource Directory

The NYSDOH AIDS Institute has a resource directory intended for use by individuals seeking services and as a referral tool for providers. This directory is arranged by region, with each organization listed under the region it services, and then by the service(s) it provides. This directory can be found at the DOH website at health.ny.gov/diseases/aids/

Partner Notification (PN)

Medical providers should discuss partner notification (PN) with their HIV-infected patients periodically throughout care. The PN regulation prioritizes newly diagnosed persons with HIV for PN activities. Follow-up by Partner Services (see below) staff will occur primarily in these cases. Providers should report partners of newly diagnosed HIV cases using the medical provider report form No. 4189.

In addition to positive HIV antibody results, laboratories are required to report electronically to the NYSDOH all viral load test results, all CD4 count and percentage results, and all genetic resistance profiles of HIV-positive persons. These results must include patient name, address, date of birth, sex, race/ethnicity, and the ordering provider name and address. Since laboratory reports do not include partner/contact, risk factor and testing history information, medical providers are required to submit a *Medical Provider Report Form* (PRF) (DOH-4189 revised 8/05) for all reportable cases.

For initial diagnosis of AIDS, providers should complete a report form. If there are known contacts, including spouses, who are to be notified, providers should use a report form to report them, or give their names to surveillance staff that will be actively following up to obtain surveillance information.

NYS Partner Services (PS)

Partner Services (or Contact Notification Assistance Program – CNAP - in New York City) is a public health program that has many years of experience working with the partners of HIV positive clients. PS staff can assist health care providers in the following areas:

- Working collaboratively to address the partner notification needs of patients.
- Providing consultation to health care providers who are coaching patients through self-notification.
- Reviewing good practices for conducting a provider-assisted notification.
- Clarifying questions about HIV confidentiality and partner notification.
- Providing information about accessing HIV counseling and testing services.
- Providing information about the specific conditions under which a physician, PA or NP may notify a partner of exposure to HIV without the patient's consent.

Information about this program is available at the following number:

- PS (Statewide, outside NYC) 1-800-541-2437 (available 9 a.m.-5 p.m. weekdays)

Additional NYSDOH AIDS Institute HIV clinical resources can be found at hivguidelines.org

8.4.7 NYSDOH Reporting Requirements

Public Health Law Article 21 (Chapter 163 of the Laws of 1998) requires the reporting of persons with HIV as well as AIDS to the NYSDOH within 21 days of diagnosis. The law also requires that reports contain the names of sexual or needle-sharing partners known to the medical providers or whom the infected person wishes to have notified. A NYDOH reporting form, the Medical Provider Report Form (DOH-4189) must be completed for persons with the following diagnoses:

1. Initial/New HIV diagnosis - First report of testing documenting antibody positive test results.
2. Previously diagnosed HIV infection (non-AIDS) - Infection previously diagnosed (including repeat/confirmatory test) but patient has not met criteria for AIDS. (Applies to a medical provider who is seeing the patient for the first time.)
3. Initial/New Diagnosis of AIDS - Including <200 CD4 cells/µL or opportunistic infection (AIDS-defining illness).
4. Previously diagnosed AIDS - (Applies to a medical provider who is seeing the patient for the first time.)

Blank forms are available by calling the NYSDOH 518-474-4284. The NYSDOH Bureau of HIV/AIDS Epidemiology and the New York City Department of Health and Mental Hygiene HIV Surveillance and Field Services Program will also work with clinicians to understand the documentation needed for reporting of HIV and AIDS diagnoses as required by Public Health Law 2130. For more detailed information related to the NYSDOH reporting requirements, see the DOH website at
http://www.health.ny.gov/diseases/aids/providers/regulations/index.htm

8.4.8 Facilitation of Referrals and Access to Care and Services for HIV Infected Patients

Advances in treatment have made it possible for HIV-infected persons to live longer, healthier lives. Early entry into care is critical, and the improved health of HIV-infected persons on antiretroviral therapy has contributed to an improved understanding of the importance of referral to care.

The clinician who receives a patient's confirmed positive HIV test result must make an appointment or schedule an appointment for follow-up HIV medical care as soon as possible after the positive test results are received. If the clinician does not provide HIV medical care, the patient's medical record should reflect the name of the medical provider/facility where the appointment was made. Providers also should explain that if a person with HIV appears to have fallen out of care, he or she may be contacted by the medical provider or health department staff to address barriers to entry into care and promote engagement in

care. For more information on finding HIV providers, go to health.ny.gov/diseases/aids/ to find additional resources.

The *HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV-Related Information* allows individuals to use a single form to authorize release of general medical information, as well as HIV-related information, to more than one provider and to authorize designated providers to share information between and among them. This form can be found at the DOH website at nygov/diseases/aids/providers/forms/index.htm

8.4.9 Care of HIV Positive Individuals

The NYSDOH AIDS Institute clinical guidelines and standards of care pertaining to HIV prevention and the medical management of adults, children, and adolescents with HIV infection can be found on the DOH website at health.ny.gov/diseases/aids/providers/standards/index.htm
Additional HIV guidelines information also can be found at hivguidelines.org

Excellus BlueCross BlueShield Participating Provider Manual

9.0 Medicare Advantage Programs

This section of the manual is intended for providers who participate in Medicare Advantage programs. The following provisions apply to all Medicare Advantage programs.

9.1 Definition of Terms

For the purposes of this section:

Appeal means any of the procedures that apply to the review of adverse Health Plan determinations on the health care services a member believes he/she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the member's health), or on any amounts the member must pay for a service. These procedures include reconsideration by Excellus BlueCross BlueShield and, if necessary, an Independent Review Entity (IRE), hearings before an Administrative Law Judge (ALJ), review by the Medicare Appeals Council (MAC), and judicial review.

Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) means organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve care given to Medicare members. BFCC-QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare health plans, and ambulatory surgical centers. BFCC-QIOs also review continued stay denials for members receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and comprehensive outpatient rehabilitation facilities (CORFs).

Complaint means any expression of dissatisfaction made by a member, orally or in writing, to Excellus BlueCross BlueShield, a provider, facility, or a Beneficiary and Family-Centered Care Quality Improvement Organization. This can include concerns about the operations of providers or Excellus BlueCross BlueShield, such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to the member, the claims regarding the right of a member to receive services or receive

payment for services previously rendered. It also includes Excellus BlueCross BlueShield's refusal to provide services to which the member believes he/she is entitled. A complaint may be either a grievance or an appeal, or a single complaint could include elements of both.

Contract means the agreement between Excellus BlueCross BlueShield and the Centers for Medicare & Medicaid Services (CMS) enabling Excellus BlueCross BlueShield to offer Medicare Advantage plans.

Covered Services means health care services covered under a member's Medicare Advantage plan offered by Excellus BlueCross BlueShield.

Effectuation means compliance with a reversal of Excellus BlueCross BlueShield's original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

Grievance means any complaint or dispute (other than one involving an organization determination) expressing dissatisfaction with the manner in which Excellus BlueCross BlueShield or its delegated entity provides health care services, regardless of whether any remedial action is taken. A member or his/her representative may make the complaint or dispute, either orally or in writing, to Excellus BlueCross BlueShield, facility or provider. An expedited grievance may also include a complaint that Excellus BlueCross BlueShield refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Independent Review Entity means an independent entity contracted by CMS to review Excellus BlueCross BlueShield's adverse reconsiderations of organization determinations.

Inquiry means any oral or written request to Excellus BlueCross BlueShield, provider, or facility without an expression of dissatisfaction, such as a request for information or action by a member. Inquiries are routine questions about benefits (i.e., inquiries are not complaints) and do not automatically invoke the grievance or organization determination process.

Member means a Medicare eligible individual who is enrolled in a Medicare Advantage plan offered by Excellus BlueCross BlueShield.

Organization Determination means any determination made by Excellus BlueCross BlueShield with respect to any of the following:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services
- Payment for any other health services furnished by a provider other than Excellus BlueCross BlueShield that the member believes are covered under

Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Excellus BlueCross BlueShield

- Excellus BlueCross BlueShield's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by Excellus BlueCross BlueShield
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment, or
- Failure of Excellus BlueCross BlueShield to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member
- Medicare Savings Accounts (MSA) only: Decisions regarding whether expenses, paid for with money from the MSA Bank Account or paid for out of pocket, constitute Medicare expenses that count toward the deductible; and, prior to satisfying the deductible, decisions as to the amount the enrollee had to pay for a service. ***Participation Agreement*** means the agreement between Excellus BlueCross BlueShield and any provider for the provision of covered services to members, either directly or through an intermediary organization

Provider means any health care services provider with whom Excellus BlueCross BlueShield contracts, either directly or through an intermediary organization, for the provision of Covered Services to members.

Quality of Care Issues means issues pertaining to the quality of services or care provided to a member that may be raised through Excellus BlueCross BlueShield's grievance process and/or through a BFCC-QIO. A BFCC-QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by Excellus BlueCross BlueShield meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration is a member's first step in the appeal process after an adverse organization determination; Excellus BlueCross BlueShield or IRE may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Representative is an individual appointed by a member or other party, or authorized under State or other applicable law, to act on behalf of a member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member or party in obtaining an organization determination, in filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described in 42 CFR part 405.

Urgently Needed Care refers to a non-emergency situation in which: (i) the member is temporarily absent from Excellus BlueCross BlueShield's service area; (ii) the member is in need of medical attention right away for an unforeseen illness, injury or condition and (iii) it is not reasonable, given the circumstances, to require the member to obtain services through Excellus BlueCross BlueShield's contracted providers.

9.2 Program Summary F

Excellus BlueCross BlueShield has contracted with CMS to offer Medicare Advantage plans to Medicare-eligible individuals. For a list of available plans, see the product portfolio elsewhere in this manual.

Excellus BlueCross BlueShield uses the Medicare regulations and guidelines to determine coverage and reimbursement.

9.2.1 Eligibility and Enrollment

Source: Medicare Managed Care Manual, Chapter 2, sections 20, 50, 50.1

Enrollment in, or voluntary disenrollment from, a Medicare Advantage program is a beneficiary election and is subject to federal government regulations. CMS has established periods in which a *beneficiary may make an election. For some such periods, there is a limit on the number of elections* that may be made.

A Medicare beneficiary may enroll in a Medicare Advantage program if he/she is entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and B as of the effective date of coverage under the plan, and meet other eligibility requirements.

Excellus BlueCross BlueShield may not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS.

9.2.2 Discrimination Against Medicare Beneficiaries Prohibited

Source: Medicare Managed Care Manual, Chapter 4, Section 10.5.2

Except for not enrolling most individuals who have been medically determined to have end-stage renal disease, Excellus BlueCross BlueShield may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in one of its Medicare Advantage health benefit programs on the basis of any factor related to the member's health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence; and
- Disability

An individual who develops end-stage renal disease while enrolled in an MA plan offered by Excellus BlueCross BlueShield is eligible to remain in an MA plan.

Excellus BlueCross BlueShield observes the provisions of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act of 1973, and the Americans with Disabilities Act. Excellus BlueCross BlueShield has procedures in place to ensure that a member is not

discriminated against in the delivery of health care services consistent with the benefits covered in the member's policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

9.2.3 General Coverage Information

Source: Medicare Managed Care Manual, Chapter 4

The following paragraphs detail *some* of the general benefits that, according to CMS, Medicare Advantage benefit packages must include. Members of Medicare Advantage health benefit programs may receive many other benefits in addition to those listed here. For details, see the product descriptions on Excellus BlueCross BlueShield's website.

Note: For benefit information specific to any Medicare Advantage member, call Customer Care. Telephone numbers are included on the *Contact List* in this manual.

According to CMS, all Medicare Advantage benefit packages must offer coverage that includes:

- No waiting periods or exclusions from coverage due to pre-existing conditions
- Ambulance services dispatched through 911 or its local equivalent where other means of transportation would endanger the member's health (42 CFR 49.40)
- Emergency and urgently needed services supplied without prior authorization, whether the services are obtained from participating or non-participating providers
- Maintenance and post-stabilization care services: that is, covered services related to an emergency medical condition and that are provided after the member is stabilized either to maintain the member's stabilized condition or, under certain circumstances to improve or resolve the member's condition
- Medically necessary dialysis from any qualified provider that the member selects when he/she is temporarily absent from Excellus BlueCross BlueShield's service area and cannot reasonably access Excellus BlueCross BlueShield's contracted dialysis providers
- Screening mammography and influenza vaccinations that require no referral and no copayment
- Original Medicare covered services, such as inpatient medical, surgical and psychiatric hospitalization that are only covered for the duration of the benefit period

9.2.4 Member Protections

Providers shall cooperate with Excellus BlueCross BlueShield to ensure that an initial assessment of each member's health care needs is completed within 90 days after the effective date of enrollment.

Providers shall provide covered services to members in a manner consistent with professionally recognized standards of health care.

Providers may not hold any member liable for payment of any fee that is the legal obligation of Excellus BlueCross BlueShield.

Providers shall continue to provide covered services to members for the duration of the contract period for which CMS has made payments to Excellus BlueCross BlueShield.

In the event that (i) Excellus BlueCross BlueShield's contract with CMS terminates, or (ii) Excellus BlueCross BlueShield becomes insolvent, participating providers must continue to provide covered services through the date of discharge to all members who are hospitalized.

9.2.5 Quality Assurance and Improvement

The Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. Providers must cooperate with the activities of a BFCC-QIO approved by CMS in connection with the provision of covered services to members, including providing the BFCC-QIO with pertinent patient care data such as information on health outcomes and information on Medicare enrollee satisfaction.

Providers must participate in and cooperate with any Quality Assurance, Quality Improvement, and/or Resource Management program established or adopted by Excellus BlueCross BlueShield. Excellus BlueCross BlueShield shall consult with, and solicit input from, providers regarding Excellus BlueCross BlueShield's medical policy, quality assurance program, and medical management procedures. Providers must agree to cooperate with Excellus BlueCross BlueShield to ensure that the following standards are met:

- Practice guidelines and utilization management guidelines are based on reasonable medical evidence or a consensus of health care professionals in the particular field
- Guidelines consider the needs of the enrolled population, and are developed in consultation with contracting health care professionals
- Guidelines are reviewed and updated periodically
- Guidelines are communicated to providers and, as appropriate, to members
- Decisions with respect to utilization management, member education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines

9.3 Provider Obligations

The obligations of each participating provider that are specifically applicable to Medicare enrollees are detailed in the provider's agreement with Excellus BlueCross BlueShield, including obligations Excellus BlueCross BlueShield delegates to the provider and obligations Excellus BlueCross BlueShield permits the provider to delegate or subcontract.

The agreement also stipulates requirements and conditions for:

- Reporting and disclosure
- Access to books and records
- Retention of information
- Accountability
- Claims turnaround time
- HIPAA – release of information

- Excellus BlueCross BlueShield's termination of participation in a Medicare Advantage contract

Excellus BlueCross BlueShield shall not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an individual who is a patient and enrolled in a Medicare Advantage plan, about:

- the patient's health status, medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options
- the risks, benefits and consequences of treatment or non-treatment; or
- the opportunity for the individual to refuse treatment and to express preference about future treatment decisions

Healthcare professionals must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. Health care professionals must ensure that individuals with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

9.4 Audits/Reviews of Medicare Advantage Programs

CMS has implemented a risk-adjusted payment methodology for Medicare Advantage programs. The methodology is based on diagnostic information as well as demographic information. In providing covered services to Medicare enrollees, providers agree to comply with access and reporting requirements.

9.4.1 Medicare Advantage ICD-CM Diagnosis Coding Review

The Centers for Medicare & Medicaid Services requires Excellus BlueCross BlueShield to confirm that all diagnoses are collected and submitted with correct ICD-CM codes (current version). Therefore, Excellus BlueCross BlueShield will be conducting ICD-CM Coding Validation Reviews of selected diagnosis codes submitted by physicians who participate in the network of Medicare Advantage providers. The code review will help Excellus BlueCross BlueShield comply with CMS regulations and assist participating physicians in achieving maximum appropriate reimbursement. (Refer to the information on accurate and complete ICD-CM coding in the *Billing and Remittance* section of this manual.)

During this review, Excellus BlueCross BlueShield requires that a copy of the pertinent medical record be obtained to support the requirements of CMS. A request for medical record documentation will be initiated by Excellus BlueCross BlueShield's Medicare Division staff or by a designated third party of Excellus BlueCross BlueShield. Should you be chosen to participate in a review of this type, your office will be notified regarding the review time frames. Following this notification, a representative will contact your office by phone and

will also arrange a method of record retrieval that is most convenient for you. You may choose to submit the medical records by scheduling a time for a reviewer to come to your office to electronically scan your records, or you may choose to return the records by mail or fax. Electronic transmittal also is available for those offices that have electronic medical records.

9.4.2 Medicare Advantage Risk Adjustment Data Validation Audit

Source: CMS Instructions for Medicare Advantage Risk Adjustment Data Validation Audit

The Centers for Medicare & Medicaid Services (CMS) conducts data validation every year after risk adjustment data are collected and submitted, and payments are made to Excellus BlueCross BlueShield. The purpose of the risk adjustment data validation is to ensure risk-adjusted payment integrity and accuracy. Risk Adjustment Data Validation (RADV) is the process of verifying that diagnosis codes submitted for payment by Excellus BlueCross BlueShield are supported by medical record documentation for a member (according to coding guidelines).

Overview of CMS Risk Adjustment Data Validation Audit

The Medicare Advantage Risk Adjustment Data Validation Audit (RADV Audit) is accomplished through medical record review. A staff member (Revenue Integrity Coding Coordinator) of Excellus BlueCross BlueShield's Government Programs Division will initiate the review with a letter to each provider selected for review; this letter will include a listing of Medicare Advantage members identified for audit. In addition to the request, a letter from CMS also will be provided, asking for this information. The staff member will contact you following the mailing of the notification to coordinate the medical record retrieval in a manner convenient for you.

Excellus BlueCross BlueShield requires that a copy of the medical record be provided to substantiate the results of the audit by CMS. The medical record documentation is required to record pertinent facts, findings and observations about a member's health status, including past and present illnesses, examinations, test, treatments and outcomes. The guiding principle for validation states the risk adjustment diagnosis must be:

- Based on clinical medical record documentation from a face-to-face encounter
- Coded according to the ICD-CM Guidelines for Coding and Reporting
- Assigned based on dates of service within the data collection period; and
- Submitted to Excellus BlueCross BlueShield from an appropriate:
  - Risk adjustment (RA) provider type (inpatient, outpatient and physician)
  - Physician data source (refer to RA physician specialty list)

Technical Medical Record Requirements

A medical record represents one face-to-face encounter on one date of service (for outpatient and physician records) or a date range (for inpatient records). Per CMS, medical records must meet the following requirements:

- The patient name must be listed on every page of the medical record
- The date of service must be listed on every page of the medical record and should also be within the data collection period

- The medical record should list an acceptable risk adjustment provider type and physician specialty
- All medical records must include a valid signature and credentials. If this is missing, a CMS-generated attestation will be required

The primary goals of risk adjustment data validation are to:

- **Identify**
  - Continued risk adjustment discrepancies
  - Organizations in need of technical assistance to improve quality of risk adjustment data
- **Measure**
  - Accuracy of risk adjustment data
  - Impact of discrepancies on payment
- **Improve/Inform**
  - Quality of risk adjustment data
  - The CMS risk adjustment models

For more information about the ICD-CM Diagnosis Coding Validation Review or Medicare Advantage Risk Adjustment Data Validation Audit, call the number listed for Medicare Advantage Coding Review on the *Contact List* in this manual.

9.5 Member Grievances, Organization Determinations and Appeals

Source: Medicare Managed Care Manual, Chapter 13, 10.3, 10.3.1, 10.3.2, 10.3.3.

Relative to grievances, organization determinations and appeals, the rights of a Health Plan Medicare Advantage member include, but are not limited to, the following:

Grievances

- The right to have grievances heard and resolved in accordance with Medicare guidelines
- The right to request from Excellus BlueCross BlueShield quality of care grievance data
- The right to file a quality of care grievance with a BFCC-QIO

Organization Determinations

- The right to a timely organization determination
- The right to request an expedited organization determination or an extension, and, if the request is denied, the right to receive a written notice that explains the member's right to file an expedited grievance
- The right to a written notice from Excellus BlueCross BlueShield of its own decision to take an extension on a request for an organization determination, which explains the reasons for the delay and explains the member's right to file an expedited grievance if he or she disagrees with the extension

- The right to receive information from Excellus BlueCross BlueShield regarding the member's ability to obtain a detailed written notice from Excellus BlueCross BlueShield regarding the member's services
- The right to receive from Excellus BlueCross BlueShield a detailed written notice of Excellus BlueCross BlueShield's decision to deny, terminate or reduce a payment or service in whole or in part, or to reduce the level of care in an ongoing course of treatment, which includes the member's right to appeal

Appeals

- The right to request and receive appeal data from Excellus BlueCross BlueShield.
- The right to request an expedited reconsideration
- The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE)
- The right to automatic reconsideration by an IRE when Excellus BlueCross BlueShield upholds its original adverse determination in whole or in part
- The right to an Administrative Law Judge (ALJ) hearing if the IRE upholds the original adverse determination in whole or in part, and the remaining amount in controversy meets the appropriate threshold requirement
- The right to request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the member in whole or in part
- The right to judicial review of the hearing decision if the ALJ hearing and/or MAC review is unfavorable to the member, in whole or in part, and the amount remaining in controversy meets the appropriate threshold requirement
- The right to file a quality of care grievance with a BFCC-QIO
- The right to request a BFCC-QIO review of a termination of coverage of inpatient hospital care
- The right to request a BFCC-QIO review of a termination of services in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities
- The right to request and be given timely access to the member's case file and a copy of that case, subject to federal and state laws regarding confidentiality of patient information. (Excellus BlueCross BlueShield has the right to charge the member a reasonable amount for duplicating the case file material.)
- The right to challenge local and national coverage determinations

For more information about these and other member rights, contact Customer Care. (See the *Contact List* in this manual.)

9.6 Grievances

A member may file a grievance with Excellus BlueCross BlueShield for the following types of issues:

- Problems with the quality of the medical care or services provided, including quality of care during a hospital stay
- Disagreement with Excellus BlueCross BlueShield's denial to give an expedited appeal

- Disagreement with Excellus BlueCross BlueShield's decision to extend the time frame for making an initial decision or appeal, in which case the member may request an expedited grievance
- The member believes he/she is being encouraged to disenroll from Excellus BlueCross BlueShield's Medicare Advantage plan
- Difficulty getting through on the telephone or problems with Customer Care
- Problems with waiting on the phone, in a provider's waiting room, or in a provider's examination room
- Problems with getting appointments when needed, or in a timely fashion
- Disrespectful or rude behavior by providers, receptionists or other staff
- Cleanliness or condition of providers' offices, clinics or hospitals
- Physician behavior and demeanor, adequacy of facilities and other similar member concerns
- Involuntary disenrollment situations (although disenrollment for cause requires prior CMS approval); and
- Timeliness of services

Procedure

Note: The grievance procedures presented in this section of the manual do not apply whenever the Medicare Reconsideration/Appeals Procedures are applicable**.**

1. Members may register grievances orally, in writing, or in person no later than sixty (60) calendar days after the event.

2. Excellus BlueCross BlueShield will respond to most grievances in writing within thirty (30) calendar days from the date the request is received. If the delay would significantly increase the risk to the member's health, Excellus BlueCross BlueShield will respond to the Grievance within seventy-two (72) hours of receipt of the request. However, if the member is filing the grievance because Excellus BlueCross BlueShield has determined not to give the member an expedited initial decision or an expedited appeal on a request for service, or if Excellus BlueCross BlueShield extends the time frame of an initial decision or appeal, Excellus BlueCross BlueShield will respond within twenty-four (24) hours from receipt of the request.

   All decision notifications will include information about the basis of Excellus BlueCross BlueShield's decision. Grievances involving clinical decisions will be made by qualified clinical personnel. Members have the right to have a representative file and/or pursue a Grievance on their behalf.

9.7 Organization Determinations

Source: Medicare Managed Care Manual, Chapter 13, Section 30.

Note: The following paragraphs apply ONLY to Medicare Advantage programs. For information about Excellus BlueCross BlueShield's

utilization review process as applicable to other health benefit programs, see the *Benefits Management* section of this manual.

An *organization determination* is any determination (i.e., an approval or denial) made by Excellus BlueCross BlueShield for a member of a Medicare Advantage health benefit program regarding:

- Payment for temporarily out of the area renal dialysis services
- Payment for emergency services, post-stabilization care, or urgently needed services
- Payment for any other health care services furnished by a provider that the Medicare Advantage member believes are covered under Medicare or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Excellus BlueCross BlueShield
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services that a Medicare Advantage member believes should be furnished or arranged for by Excellus BlueCross BlueShield
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment, or
- Failure of Excellus BlueCross BlueShield to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay adversely affects the health of the member
- Medicare Savings Accounts (MSA) only: Decisions regarding whether expenses, paid for with money from the MSA Bank Account or paid for out of pocket, constitute Medicare expenses that count toward the deductible; and, prior to satisfying the deductible, decisions as to the amount the enrollee had to pay for a service

The following sections describe the procedures Excellus BlueCross BlueShield has established for making timely organization determinations regarding the benefits a member is entitled to receive under his/her Medicare Advantage plan.

Once an "organization determination" has been made, the appeals process may be triggered if a member believes that Excellus BlueCross BlueShield's decision is unfavorable. In the presence of any adverse organization determination — that is, when Excellus BlueCross BlueShield determines that it will not provide or pay for a requested service, in whole or in part, or if Excellus BlueCross BlueShield discontinues or reduces a service — Excellus BlueCross BlueShield must send the member a written denial notice that includes appeal rights.

If a member of a Medicare Advantage program disputes an organization determination, Excellus BlueCross BlueShield will follow the procedures outlined in paragraphs 9.8.

If a member complains about any other aspect of Excellus BlueCross BlueShield, (e.g., the manner in which care was provided), the grievance process described above will apply. Generally, Excellus BlueCross BlueShield will consider complaints about quality of care as grievances, but such complaints may also be received and acted upon by a Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO).

9.7.1 Standard Organization Determinations

Source: Medicare Managed Care Manual, Chapter 13, Section 40.

When a Medicare Advantage member requests a service, Excellus BlueCross BlueShield must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date Excellus BlueCross BlueShield receives the request for a standard organization determination.

Excellus BlueCross BlueShield may extend the time frame up to an additional 14 calendar days for non-participating providers. This extension is allowed to occur if the member requests the extension or if Excellus BlueCross BlueShield justifies a need for additional information and documents how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change Excellus BlueCross BlueShield's decision to deny). When Excellus BlueCross BlueShield grants itself an extension to the deadline, it must notify the member, in writing, of the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with Excellus BlueCross BlueShield's decision to grant an extension. Excellus BlueCross BlueShield must notify the member, in writing, of its determination as expeditiously as the member's health condition requires, but no later than the expiration of any extension that occurs.

If Excellus BlueCross BlueShield fails to provide the member with a timely notice of an adverse determination, this failure itself constitutes an adverse organizational determination and may be appealed.

9.7.2 Expedited (or "Fast") Organization Determinations

Source: Medicare Managed Care Manual, Chapter 13, Section 50.

A Medicare Advantage member or any physician (regardless of whether the physician is affiliated with Excellus BlueCross BlueShield) may request that Excellus BlueCross BlueShield expedite an organization determination when the member or his/her physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

> **Note:** Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. However, if the case includes both a payment denial and a pre-service denial, the member has a right to request an expedited appeal for the pre-service denial.

Excellus BlueCross BlueShield will evaluate a request for an expedited determination and will promptly determine whether to approve the request. If the member's physician initiated the request for a fast determination, or if the member initiated the request for a fast determination with the support of his/her physician, Excellus BlueCross BlueShield automatically will expedite the determination.
If Excellus BlueCross BlueShield decides to expedite the request, it must render a decision as expeditiously as the enrollee's health condition might require, but no later than 72 hours after receiving the enrollee's request.

If Excellus BlueCross BlueShield denies a request for a fast determination, Excellus BlueCross BlueShield will provide oral notice of the determination, with a written notice to follow within three (3) calendar days and will automatically transfer the request to a standard organization determination within a fourteen (14) calendar-day timeframe. Excellus BlueCross BlueShield may take an additional 14 calendar days if the member requests the extension, or if it is to the member's benefit. The notice will state that the request will be processed using the time frame for standard determinations, and that the member has the right to resubmit the request for an expedited determination or file with Customer Care an expedited grievance regarding this decision. The notice also will provide instructions on how to file a grievance.

9.7.3 Notification of Adverse Determinations

Source: Medicare Managed Care Manual, Chapter 13, Section 40.2.1.

Notification by Provider

In situations where a member disagrees with a provider's decision to deny a service or course of treatment in whole or in part, the provider must notify the member of his/her right to request and receive from Excellus BlueCross BlueShield a detailed written notice regarding the provider's decision. The provider's notification must include information about how to contact Excellus BlueCross BlueShield.

Notification by Excellus BlueCross BlueShield

If Excellus BlueCross BlueShield decides to deny, discontinue or reduce services or payment, in whole or in part, and the member believes the services should be covered, then Excellus BlueCross BlueShield must give the member a written notice of its determination. This written notice will include:

- The specific reason for the denial that takes into account the member's presenting medical condition, disabilities, and special language requirements, if any
- Information regarding the member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the member's behalf
- For service denials, a description of both the standard and expedited reconsideration processes and the time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeal process
- For payment denials, a description of the standard reconsideration process and time frames, and the rest of the appeals process; and
- Notice of the member's right to submit additional evidence in writing or in person

9.8 Appeals Process

Source: Medicare Managed Care Manual, Chapter 13, 10.3.3, 130.2

There are various levels of appeal available to members of Medicare Advantage health benefit programs following the receipt of notification of an adverse organization determination. These levels are to be followed sequentially only if the original denial continues to be upheld by the reviewing entity.

- Reconsideration of an adverse organization determination made by Excellus BlueCross BlueShield
- Automatic review by an Independent Review Entity (IRE) when Excellus BlueCross BlueShield denies any part of the reconsideration request
- Hearing by an Administrative Law Judge (ALJ), if the amount in controversy is at least that established each year by the federal government
- Review by a Medicare Appeals Council (MAC); and

Federal Court Review if the amount in controversy is at least that established each year by the federal government.

- The right to challenge local and national coverage determinations. Individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the DAB of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs

An initial, revised or reconsideration determination made by Excellus BlueCross BlueShield can be reopened:

- Within one year for any reason
- Within four years for just cause
- At any time for clerical correction or in cases of fraud; and
- At any time for a decision under the coverage (National Coverage Determination – NDC) appeals process

IRE, ALJ and MAC may reopen reconsideration, hearing or review decisions, respectively, for good cause within 180 days from the date of decision, or at any time if the decision was procured by fraud or similar fault.

9.8.1 Right to Reconsideration

- A member has the right to an appeal (also called a "reconsideration") if he/she does not agree with Excellus BlueCross BlueShield's decision about medical care or services (i.e., after receiving an adverse organization determination).
- A member may appeal if he/she believes:
- Excellus BlueCross BlueShield has not paid a bill
- Excellus BlueCross BlueShield has not paid a bill in full
- Excellus BlueCross BlueShield will not approve or give care it should cover, or a provider will not provide care or referrals the member thinks he or she needs
- Excellus BlueCross BlueShield is stopping care that the member still needs

Note: If a member is discharged from a hospital and the member feels it is too soon, the member must request an immediate BFCC-QIO review. The member may remain in the hospital without becoming financially liable until the BFCC-QIO makes its decision.

9.8.2 Who May Request Reconsideration?

- A member may act on his/her own behalf
- A physician may file an internal appeal on the member's behalf without a formal appointment of representative form for pre-service denials
- A member may appoint an authorized representative to act on his/her behalf, e.g., a doctor, a friend, or a lawyer. To appoint an authorized representative, the member must:
  - Sign, date and complete an Appointment of Representative, Form CMS-1696
  - Have the authorized representative sign and date the statement
- A representative appointed by a member, unless revoked, is considered a valid appointee for one year from the date that the appointment is signed by both the member and the representative
- Either the signed representative form or other appropriate legal papers supporting an authorized representative's status must be included with each appeal
- A provider, physician or supplier may not charge a member for representation in an appeal. Administrative costs incurred by a representative during the appeals process are not reasonable costs for Medicare reimbursement purposes
- A provider who does not participate with the specific Medicare Advantage program may file a standard appeal of a denied claim if he/she completes a waiver of liability statement that says he/she will not bill the member regardless of the outcome of the appeal. (See the last paragraph in this section of the manual for additional information about physician appeals)
- A court-appointed guardian or an agent under a health care proxy may act as the member's representative to the extent provided under New York state law

9.8.3 Support for Member Appeals

Excellus BlueCross BlueShield must gather all the information it needs to make a decision about the member's appeal. If Excellus BlueCross BlueShield requires the member's assistance in gathering this information, Excellus BlueCross BlueShield will contact the member directly.

A member has the right to obtain and include additional information as part of his/her appeal. For example, a member may already have documents related to the issue, or he/she may want to obtain his/her provider's records or the provider's written opinion to help support the request. The provider may ask the member to submit a written request in order to obtain such information.

9.8.4 How to Request a Standard Reconsideration

A member may request a standard reconsideration, orally (by telephone), or in writing, by filing a signed request with Excellus BlueCross BlueShield. Except in the case of an extension of the filing time frame, a member must file the request for reconsideration within 60 calendar days from the date of the notice of the organization determination. The following steps should be taken:

- The request should be recorded in the member's own words, repeated back to the member to confirm the accuracy, and placed into a tracking system
- If a department other than one that responds to appeals receives the request, it should forward the request to the appropriate department handling appeals

Excellus BlueCross BlueShield mails an acknowledgment letter to the member confirming the facts and basis of the appeal.

9.8.5 Reconsideration by Excellus BlueCross BlueShield

Standard Appeals

Excellus BlueCross BlueShield normally has 30 calendar days from the date of receipt of the request for standard reconsideration to process a member's request for reconsideration for a pre-service matter. A faster, 72-hour appeal is also available if waiting 30 days for a standard appeal could seriously harm the member's health or ability to function (see *Expedited 72-hour Appeals*, below).

Excellus BlueCross BlueShield has 60 calendar days from the date of receipt of the request for standard reconsideration to process a member's appeal regarding claims payment or reimbursement or post service matter. The expedited process is not available for these types of appeals.

Excellus BlueCross BlueShield may extend the time frame by up to 14 calendar days if the member requests the extension, or if Excellus BlueCross BlueShield justifies a need for additional information and documents how the delay is in the interest of the member. Excellus BlueCross BlueShield must notify the member in writing of the reasons for the delay and of its intent to extend the time frame before the end of the 30 or 60 days.

Expedited 72-hour Appeals

The member, any physician, or the member's authorized representative may request a "fast" appeal rather than a "standard" appeal for a decision about medical care where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function. If **any** physician asks for a fast decision on a member's behalf, or supports a member in his/her request for one, and the physician indicates that waiting for a standard decision could seriously harm the member's life, health or ability to regain maximum function, Excellus BlueCross BlueShield will automatically grant the member a fast decision.

If the member requests a fast appeal without support from a physician, Excellus BlueCross BlueShield will decide if the member's health requires it. If Excellus BlueCross BlueShield decides that the member's medical condition does not meet the requirements for a fast appeal, Excellus BlueCross BlueShield will provide the member with prompt oral notice of the denial and the member's rights and mail the member a letter within three calendar days that explains that, if the member gets a physician's support for a "fast" appeal, Excellus BlueCross BlueShield will automatically make a fast decision. The letter will also explain how

the member may file an expedited Grievance if the member disagrees with Excellus BlueCross BlueShield's decision to deny the member's request for a fast appeal.

Once Excellus BlueCross BlueShield denies a member's request for a fast initial decision, Excellus BlueCross BlueShield will make its decision within the standard time frame (as explained in ***Standard Appeals***, above).

> **Note:** If, after requesting an appeal, a member wishes to withdraw the appeal, he/she must do so by sending a written notice to Customer Care (for Health Plan address and phone numbers, see the *Contact List* in this manual.)

Following the Reconsideration

If, following standard or expedited reconsideration, Excellus BlueCross BlueShield does not rule fully in the member's favor, Excellus BlueCross BlueShield must submit a written explanation with a complete case file to the Independent Review Entity (IRE) contracted with CMS. The member's appeal also must be forwarded to the IRE if Excellus BlueCross BlueShield fails to provide the member with a reconsidered determination within the time frames specified above.

9.9 Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) Review F

Medicare Advantage members have a right to request a review of their discharge or Excellus BlueCross BlueShield's decision to end coverage for services received from a hospital, skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF).

A Medicare Advantage member may ask the Beneficiary and Family-Centered Care Quality Improvement Organization (the "BFCC-QIO") to do an independent review of whether it is medically appropriate to end coverage for the member's services. A BFCC-QIO is a group of physicians and health professionals paid by the federal government to monitor and help improve the quality of care provided to Medicare patients.

Participating providers shall cooperate with the activities of the BFCC-QIO in connection with any review of the provision of covered services to members, including providing BFCC-QIOs with pertinent patient care data such as information on health outcomes and information on Medicare member satisfaction.

9.9.1 New York State BFCC-QIO

There is one Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) in each state. The BFCC-QIO for New York State is Livanta. Contact information for Livanta is included on the *Contact List* in this manual.

9.9.2 QIO Review of Hospital Discharge

A member may request an immediate BFCC-QIO review if the member disagrees with Excellus BlueCross BlueShield's determination not to cover a continued hospital stay. A BFCC-QIO review allows members to remain in the hospital without incurring financial liability (except any applicable copayments or deductibles) while the review is being conducted. This review takes the place of the regular appeal process available through Excellus BlueCross BlueShield, as described in paragraphs 9.8, above. The steps involved in requesting a BFCC-QIO review are as follows:

1. Upon admission to the hospital and prior to discharge, the hospital gives the member an "Important Message From Medicare" (IM), which includes the member's appeal rights.
2. If the member believes he/she is being discharged too soon, the member contacts the BFCC-QIO listed on the IM. In order to be considered timely, the request must be made no later than midnight of the day of discharge. The request may be in writing or by telephone, and must be requested before the member leaves the hospital.
3. The BFCC-QIO calls Excellus BlueCross BlueShield on the same day the member contacts the BFCC-QIO and requests information on the case.
4. The entity that made the decision to discharge the patient (e.g. the hospital) completes a Detailed Notice of Discharge (DNOD) form (CMS-10066) that includes the clinical rationale for the discharge.
5. The hospital delivers the DNOD to the member (or his/her representative) by noon of the day after the BFCC-QIO notifies Excellus BlueCross BlueShield of the appeal.
6. Excellus BlueCross BlueShield and/or the Hospital forward the DNOD and all supporting case documentation to the BFCC-QIO by noon of the day after the BFCC-QIO notifies Excellus BlueCross BlueShield of the appeal.
7. The BFCC-QIO makes a determination on the case and notifies Excellus BlueCross BlueShield, the hospital and the member of its decision within one calendar day after it receives all pertinent information on the case. The BFCC-QIO will communicate its decisions by telephone, followed by written notice.

Excellus BlueCross BlueShield is financially responsible for coverage of services during the BFCC-QIO review. When the member makes a timely request for an appeal, he/she is not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the calendar day after the date the member receives notification of the determination by the BFCC-QIO. Liability for further inpatient hospital services depends on the BFCC-QIO decision:

- Unfavorable determination: If the BFCC-QIO does not agree with the member, liability for continued services begins at noon of the day after the BFCC-QIO notifies the member that the BFCC-QIO agreed with the discharge determination
- Favorable determination: If the BFCC-QIO agrees with the member, the patient is not financially responsible for continued care until Excellus BlueCross BlueShield and hospital once again determine that the member no longer requires inpatient care and secure the concurrence of the physician, and the hospital notifies the member with a follow-up copy of the IM

If the member makes an untimely request for an appeal (after midnight on the day of discharge or after he/she has left the hospital), the member may request an expedited reconsideration by Excellus BlueCross BlueShield but the member may be held responsible for charges incurred after the day of discharge. If the appeal is overturned, Excellus BlueCross BlueShield must continue covering the care and/or refund the member for any expenses the member incurred during the review.

A member who is dissatisfied with the BFCC-QIO decision can request a reconsideration from the BFCC-QIO within 60 days of receiving notification of the original BFCC-QIO decision. The BFCC-QIO must issue its reconsidered determination as expeditiously as the member's health requires but no later than 14 days from the date of receipt of the request. The member's financial liability is determined by the BFCC-QIO's decision. If the member is no longer in the hospital, he or she may appeal directly to an Administrative Law Judge, the MAC or a federal court.

9.9.3 Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC)

The NOMNC is an Office of Management and Budget (OMB)-approved standardized notice. The *NOMNC is a written notice designed to inform Medicare enrollees that their covered Skilled Nursing* Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), care is ending. All Medicare members receiving covered SNF, HHA or CORF services must receive a NOMNC upon termination of services, even if they agree that services should end. Although Excellus BlueCross BlueShield is responsible for either making or delegating the decision to end services, SNFs, HHAs, and CORFs are responsible for delivering the notices to Medicare members.

Completing the NOMNC

Providers must insert the following patient-specific information in the NOMNC prior to delivery to the Medicare member:

- The member's name
- The date that coverage of services ends

The name, address and telephone number of Excellus BlueCross BlueShield or provider that actually delivers the notice must appear above the title of the form. Excellus BlueCross BlueShield or provider's registered logo is not required, but may be used. If Excellus BlueCross BlueShield's name and contact information are not in the space above the title of the form, they must be displayed elsewhere on the form for the member's use in case an expedited appeal is requested, or the member or BFFC-QIO seeks Excellus BlueCross BlueShield's identification. The notice *must* also identify and provide the telephone number of the appropriate BFCC-QIO. All other required elements of the notice are included in the standardized material on the notice. The provider also has the option to include additional information in the space provided on the notice. The NOMNC may be modified for mass printing to indicate the kind of service being terminated if only one type of service is provided, such as skilled nursing, home health, or comprehensive outpatient rehabilitation facility.

Providers may not rewrite, re-interpret, or insert non-OMB approved language into the body of the NOMNC except where indicated.

NOMNC Delivery Requirements

Providers must ensure the NOMNC is validly delivered in accordance with the following:

1. The member must be able to understand the purpose and contents of the NOMNC, and understand that he or she may appeal the termination decision.
2. The member must sign and date the NOMNC to acknowledge receipt whether or not the member agrees that coverage for services should end. If the member refuses to sign the notice, the notice is still valid as long as, the provider documents that the notice was given but the member refused to sign.
3. If the member is physically unable to sign, or needs assistance of an interpreter or assistive device to read or sign, the provider should document the use of such assistance to validate the delivery.
4. The Centers for Medicare and Medicaid Services (CMS) believes valid delivery is best accomplished by face-to-face contact with the Medicare member. The provider must deliver the NOMNC in person unless the member is unable to comprehend the contents of the notice.
5. If the member is not able to comprehend the contents of the notice, it must be delivered to and signed by the member's representative.

NOMNC Delivery Requirements When a Member's Representative is Unavailable

Providers are required to develop procedures to use when the member is incapable or incompetent, and the provider cannot obtain the signature of the member's representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of a member, then the provider **must**:

1. Telephone the representative to advise him/her when the Medicare member's services are no longer covered;
2. Describe the purpose of the call, which is to inform the representative about the member's right to file an appeal;
3. Identify him/herself and provide a contact number for him/herself and Excellus BlueCross BlueShield;
4. Describe how to get a copy of a detailed notice describing why the member's services are not being provided;
5. Describe the member's appeal right to appeal to the BFCC-QIO;
6. Inform the representative of the date and time by which the appeal must be filed to take advantage of the appeal right;
7. Identify the BFCC-QIO required to receive the appeal, including any applicable name, address, telephone number, fax number or other method of communication the BFCC-QIO requires in order to receive the appeal in a timely fashion; and

8. Provide at least one telephone number of an advocacy organization, or 1-800-MEDICARE, that can provide additional assistance to the representative in further explaining and filing the appeal.

The date the provider conveys this information to the representative is the date of the receipt of the NOMNC. The provider must confirm the telephone contact by written notice mailed on that same date. The provider must place a dated copy of the written notice in the member's medical file, and document the telephone contact with the representative.

When direct phone contact cannot be made, the provider must send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. The provider must place a dated copy of the notice in the member's medical file. When the notice is returned by the post office with no indication of a refusal date, then the member's liability starts on the second working day after the provider's mailing date.

When to Deliver the Notice of Medicare Non-Coverage

SNFs, HHAs and CORFs must provide written notice (the NOMNC) to Medicare members no later than two days before the coverage of services will end.

If, upon receiving the NOMNC, the member decides to appeal the end of coverage, he/she must contact the BFCC-QIO to do an independent review of whether it is medically appropriate to end coverage of the services. BFCC-QIOs have different names, depending on which state they are in. In New York state, the BFCC-QIO is called Livanta.

The member must contact Livanta as soon as possible, but no later than noon of the day before the date that the member's coverage ends. Requests are to be by telephone or fax to:

Phone:
1-866-815-5440
TTY: 1-866-868-2289

Fax:
Appeals: 1-855-236-2423
All other reviews: 1-844-420-6671

Exclusions from NOMNC Delivery Requirements

Providers are not required to deliver the NOMNC if coverage is being terminated for any of the following reasons:

1. The member's benefit is exhausted
2. Denial of an admission to an SNF, HHA or CORF
3. Denial of non-Medicare covered services; or
4. A reduction or termination of services that do not end the skilled stay

When a Detailed Explanation of Non-Coverage (DENC) will be Issued

Excellus BlueCross BlueShield will issue a DENC explaining why services are no longer medically necessary to the member and provide a copy to the QIO no later than close of business (typically 4:30 P.M.) on the day of the QIO's notification that the member requested an appeal, or the day before coverage ends, whichever is later.

Complete instructions regarding the requirements for completing and delivering the NOMNC and DENC are available on the CMS website or from Customer Care.

http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html
http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/NOMNCInstructions.pdf

http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/DENCInstructions.pdf

If a member misses the deadline for requesting an immediate appeal with the BFCC-QIO, the member may still request an expedited appeal through Excellus BlueCross BlueShield. If the request does not meet the criteria for an expedited review, Excellus BlueCross BlueShield will review the decision under its rules for standard appeals.

9.10 Prescription Drugs Part D

9.10.1 Appealing Coverage Determinations (Redetermination)

Source: Prescription Drug Benefit Manual Chapter 18.70.1, 70.7

An appeal (redetermination) is any of the procedures that deal with the review of an unfavorable coverage determination. Members may file an appeal if they want Excellus BlueCross BlueShield to reconsider and change a decision made about what prescription drug benefits are covered or what will be paid for a prescription drug. Members cannot request an appeal if a coverage determination has not been issued. As with coverage determination exception requests, CMS requires the prescribing physician to submit a supporting statement if the member or their appointed representative requests an appeal relating to an exception request, such as a tiered cost-sharing or quantity limit appeal.

Members, or their appointed representative, must request a redetermination in writing within sixty (60) calendar days from the date of the coverage determination. They also can request an expedited or "fast appeal." These requests will be accommodated if Excellus BlueCross BlueShield determines, or the member's physician tells us, that waiting for a standard decision will seriously jeopardize the member's life or health. Once Excellus BlueCross BlueShield receives the redetermination request, Excellus BlueCross BlueShield has seven (7) days for a standard request for coverage or payment and 72 hours for an expedited request for coverage to notify the member of its decision.

The parties who may request a standard or expedited redetermination include an enrollee, an enrollee's representative, or an enrollee's prescribing physician or other prescriber. A prescribing physician or other prescriber may act on behalf of an enrollee in requesting a standard or expedited coverage determination, a standard or expedited redetermination or a standard or expedited IRE reconsideration without being the enrollee's representative. In these situations, the physician does not have all of the rights and responsibilities of an enrollee.

Under *42 CFR 423.580*, a non-representative physician or other prescriber may request a standard redetermination on an enrollee's behalf only after he or she has provided notice to the enrollee that he or she is making the appeal request (physicians or other prescribers are not required to provide such notice to enrollees when requesting expedited redeterminations).

The Part D plan sponsor must provide written notice of its redetermination, whether favorable or adverse, as expeditiously as the enrollee's health condition requires, but no later than seven (7) calendar days from the date the Part D plan sponsor receives the request for a standard redetermination.

Excellus BlueCross BlueShield Participating Provider Manual

10.0 Government Programs

10.1 Medicaid Managed Care, Child Health Plus and Blue Option Plus

Excellus BlueCross BlueShield offers HMO programs, sponsored by New York state, that are intended to help ensure medical coverage for the uninsured. These programs are Child Health Plus (CHP), Medicaid managed care (HMOBlue Option in the Excellus BlueCross BlueShield Central New York, CNY Southern Tier and Utica Regions, Blue Choice Option in the Excellus BlueCross BlueShield Rochester Region, or Premier Option in Orleans County) and Blue Option Plus, Or Premier Option Plus in Orleans County. Covered benefits vary by program and are primarily determined by New York state.

All medical care must be received or approved by the delivery system that the member has chosen. Rochester Region Child Health Plus members are not required to select a delivery system. This section is intended for providers who participate in one or all of these programs.

In addition to every provision of this *Participating Provider Manual*, the following provisions apply with regard to the government programs Child Health Plus, and Medicaid managed care.

10.1.1 Applying for CHP or Medicaid Managed Care

Prospective members may contact Excellus BlueCross BlueShield, for information about enrollment in any of these programs. The prospective members may schedule an appointment with an Excellus BlueCross BlueShield Marketplace Facilitated Enroller or Community IPA/ Navigators to provide in-person enrollment assistance. Prospective members may visit NY State of Health marketplace at info.nystateofhealth.ny.gov/IPANavigatorSiteLocations, for a list of navigators in their area or contact Excellus BlueCross BlueShield to schedule an appointment with a Marketplace Facilitated Enroller.

Prospective Child Health Plus members can apply online through the NY State of Health marketplace at https://nystateofhealth.ny.gov/.

Applicants for each of the programs must meet certain income guidelines. Income guidelines vary by program and may change from year to year.

10.1.2 Restrictions

Members of these HMO government programs must follow all the rules and guidelines of a typical HMO. This includes selecting a primary care physician (PCP) who coordinates all their care, including obtaining referrals to specialists and obtaining preauthorization for specified services. Information regarding referral and preauthorization requirements is included in the *Benefits Management* section of this manual. These requirements may vary from the requirements of Excellus BlueCross BlueShield's commercial HMO and point-of-service health benefit programs.

Excellus BlueCross BlueShield conducts utilization review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a member are medically necessary. For these programs, medically necessary means that the health care and services are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

For services to be covered, members must use providers who participate in Excellus BlueCross BlueShield's government program network, or by approval to an out-of-network provider. Not all providers participate in all programs.

10.1.3 Restricted Recipient Program

New York state mandates that individuals enrolled in the state Medicaid Restricted Recipient Program (RRP) join a managed care health plan. Restricted recipients are individuals who have been identified as abusers or misusers of the Medicaid program.

These individuals can be restricted to providers in one or more of the following categories:

- Physician, physician group
- Clinic
- Inpatient hospital
- Dental, dental clinic
- Pharmacy
- Ancillary services providers

As a result, Excellus BlueCross BlueShield can only make payment to the provider of record in these categories, or to a provider who has received a referral from the restricted member's PCP. If you are the PCP of record for a restricted member, you are required to notify Excellus BlueCross BlueShield each time you refer a restricted patient for any service that will be rendered outside of your practice. This applies to all services, not only those in restricted categories.

It will be very important that you verify member eligibility for restricted recipients. Medicaid managed care restricted recipients will have **"RRP"** listed after the last name on their member identification card. A restricted recipient can also be verified by calling Customer Care.

10.1.4 How to Select or Change PCP

Members may select or change their PCPs by:

- Calling the customer care numbers on their ID cards.
- Faxing a *PCP Selection Form* (available via our website) to Excellus BlueCross BlueShield. Providers may have the member complete it in the office and fax it to Excellus BlueCross BlueShield at the fax number listed on the form. (The fax number is also included in the *Contact List* in this manual.)

10.1.5 Lifetime Health Medical Group

The following are the Lifetime Health Medical Group health centers where Blue Choice Option members may choose to receive care. Child Health Plus members may receive their care at these health centers as well, but they are not restricted to a health care delivery system.

Lifetime Health Medical Group Health Centers
(Excellus BlueCross BlueShield Rochester Region Only)

Joseph C. Wilson Health Center 800 Carter Street Rochester, NY 14621 585-338-1400 1-800-338-3899	Marion B. Folsom Health Center 1850 Brighton-Henrietta Town Line Road Rochester, NY 14623 585-424-6210 1-800-936-5766
Greece Health Center 470 Long Pond Road Rochester, NY 14612 585-227-7600 1-800-842-6473	Perinton Health Center 77 Sully's Trail Pittsford, NY 14534 585-248-5300 1-800-270-3129

10.1.6 Family Planning Chargeback

All claims for Medicaid managed care family care planning and reproductive services must be billed to Excellus BlueCross BlueShield and not Medicaid fee-for-service.

10.1.7 Medicaid Managed Care (HMOBlue Option, Blue Choice Option, and Premier Option) Blue Option Plus/Premier Option Plus

HMOBlue Option, Blue Choice Option, and Premier Option are HMO health benefit programs for New York state residents who are eligible for Medicaid and who live in the Excellus BlueCross BlueShield service area. HMOBlue Option is for members who reside in Excellus BlueCross BlueShield's Central New York, CNY Southern Tier or Utica Regions. Blue Choice Option is for members who reside in Excellus BlueCross BlueShield's Rochester Region, and Premier Option is for members residing in Orleans County. Blue Option Plus/Premier Option Plus eligible members reside in the counties in which we offer Medicaid managed care products.

- The program maintains the benefit structure of Medicaid, but requires members to follow all of the HMO rules and guidelines. (Medical management requirements may vary slightly from Excellus BlueCross BlueShield's commercial HMO health benefit programs.)

- Some services are not part of the benefit package but rather are covered under the Medicaid fee-for-service program.
- Emergency and non-emergency transportation services are carved out of the Medicaid managed care benefit. Non-emergency transportation is handled by Medical Answering Services (MAS) www.medanswering.com. Each county has a specific MAS contact phone number.
- There is no cost to members who participate in HMOBlue Option, Blue Choice Option, Premier Option, or Blue Option Plus/Premier Option Plus. There are no premiums, deductibles, copays or coinsurance. (Limited copays apply to the prescription drug benefit). These copayments and selected services are determined by New York state and may be subject to change.
- Pharmacy benefit is managed through MedImpact
- A member's eligibility in HMOBlue Option, Blue Choice Option, Premier Option, or Blue Option Plus/Premier Option Plus is always month-to-month, from the first of the month through the last day of the month.
- The dental benefit is managed through Healthplex, Inc., an independent company (1-800-468-9868).

Please refer to the Excellus BlueCross BlueShield Blue Option Plus manual for information related to that product. Participating providers in Excellus BlueCross BlueShield's Medicaid managed care provider network can provide care to members that reside in a county that offers Excellus BlueCross BlueShield Medicaid managed care.

10.1.8 Child Health Plus

Child Health Plus is a New York state program designed to cover children and adolescents (under age 19) who are residents of New York, whose families have no comparable insurance coverage, and who are ineligible for Medicaid.

The amount of the monthly premium is based on income and family size. There are no deductibles, copayments or coinsurance.

Information is available by calling 1-800-698-4543 and asking about Child Health Plus. There is also information on the NYSDOH website, www.health.ny.gov/health_care/child_health_plus/.

Prospective CHP members may apply online through the NY State of Health marketplace at www.nysofhealth.ny.gov/.

Excellus BlueCross BlueShield makes Child Health Plus available in all counties in its service area. Members may see providers in any county as long as the provider participates in Excellus BlueCross BlueShield's Child Health Plus provider network.

Excellus BlueCross BlueShield manages pharmacy benefits for Excellus BlueCross BlueShield members. There is a closed formulary. See the *Pharmacy Management* section of this manual for additional information.

10.2 General Requirements F

10.2.1 Minimum Office Hours

In keeping with requirements established by the NYSDOH, PCPs who serve HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus and Blue Option Plus/Premier Option Plus members must practice a minimum of 16 hours at each office location.

The NYSDOH will waive this requirement under certain circumstances:

- Excellus BlueCross BlueShield must submit a waiver regarding a specific physician to the Medical Director of the NYSDOH Office of Managed Care.
- The physician must be able to fulfill the responsibilities of a PCP, as defined in the *Benefits Management* section of this manual.
- The physician must be available at least eight hours a week.
- The physician must be practicing in a Health Provider Shortage Area (HPSA) or in a similarly determined shortage area.
- The waiver request must demonstrate that there are systems in place to guarantee continuity of care and fulfillment of the appointment availability and 24-hour access standards defined in the *Quality Improvement* section of this manual.

The NYSDOH notifies Excellus BlueCross BlueShield when a waiver has been granted.

10.2.2 Identifying Members

Members of HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus and Blue Option Plus/Premier Option Plus have identification cards that include the BlueCross BlueShield "Cross and Shield" logos.

Providers can determine in which government program the member is enrolled by specific designations noted on the ID card.

Program	ID card designation	ID number
Child Health Plus	Group code "C"	Subscriber ID Number has a prefix of **VYB**
Medicaid Managed Care	Program name HMOBlue Option Blue Choice Option Premier Option	Subscriber ID Number has a prefix of **VYT** Note: For Premier products, no Alpha prefix displays on the member's card. Only the numeric ID number is displayed.
Restricted Recipient	The letters "RRP" entered into the "Title" field.	The letters "RRP' entered after the last name Example: JOHN A. DOE **RRP**
Health and Recovery Plan (HARP)	Blue Option Plus Premier Option Plus	**VYT** Note: For Premier products, no Alpha prefix displays on the member's card. Only the numeric ID number is displayed.

10.2.3 Checking Eligibility

Providers may check eligibility for HMOBlue Option, Blue Choice Option, Premier Option, Child Health Plus and Blue Option Plus/Premier Option Plus members using the inquiry methods described in this manual. In addition, eligibility information for HMOBlue Option, Blue Choice Option, Premier Option, and Blue Option Plus/Premier Option Plus members is available via the Medicaid eligibility verification system, *ePACES,* www.emedny.org/epaces/. The code for HMOBlue Option and Blue Choice Option membership is "MR."

Other options for checking eligibility are the Medicaid telephone system, or the PC Medicaid eligibility software. Providers should have the member's name, date of birth and CIN number available before calling.

> **Note:** Excellus BlueCross BlueShield recommends providers check eligibility at every visit as members may lose eligibility for government programs from month to month.
>
> **Also Note:** If the member's PCP is not listed correctly on the member ID card, the member may make a change by calling the Customer Care number on the ID card at the time of the appointment. Another option is for the provider to have the member complete the *PCP Selection Form* and fax it to the number on the form. (Form is available online at ExcellusBCBS.com/Provider *> Print Forms*.)

10.2.4 Speaking with Members

> **Note:** A complete list of Member Rights and Responsibilities is included in the *Administrative Information* section of this manual.

Excellus BlueCross BlueShield expects participating providers to maintain certain standards when speaking with members.

Participating providers must:

- Provide complete and current information concerning diagnosis, treatment and prognosis – in terms a member can understand. When it is not advisable to give such information to the member, make the information available to an appropriate person acting on the member's behalf.
- Prior to initiating a service, inform a member if the service is not covered and specify the cost of the service. Providers must notify the member in writing prior to providing a service that is not covered, informing the member that he/she will be liable for payment.
- Prior to initiating a procedure or treatment, provide the information a member needs to give informed consent. Tell the member to contact Customer care for information about accessing services not covered by Excellus BlueCross BlueShield. (For contact information, see the *Contact List* in this manual.)
- Disclosure of affiliation to patients. According to the Medicaid contract, participating providers must advise patients of their affiliation with all Managed Care plans. Participating providers may display Excellus BlueCross BlueShield's marketing materials, provided that appropriate notice is clearly posted for all health plans with which they have a contract.

10.2.5 False Claims Act Reminder

Excellus BlueCross BlueShield expects participating providers to understand the state and federal requirements regarding false claims recovery. We have policies and procedures for the detection and prevention of fraud and abuse – including detailed information about the False Claims Act.

Our policy is posted to our website, ExcellusBCBS.com. Providers participating with Medicaid managed care and Child Health Plus are also obligated to report and return overpayments to the plan within 60 days of the time when the overpayments are identified. To view our overpayment self-disclosure policy, visit our website.

10.2.6 Disclosure of Ownership and Control Information

Excellus BlueCross BlueShield contracts with Medicaid, and section 18.6(b) of Federal Regulation 42 CFR 455.104 requires that we obtain ownership and control disclosures from providers who participate in Medicaid managed care.

We are required to collect a disclosure from any individual or corporation with an ownership or control interest in a provider who contracts with us to provide Medicaid services. This requirement does not apply to individual or group practitioners. We are required to collect a disclosure from any individual or corporation with an ownership or control interest of 5 percent or more in a provider who contracts with us to provide Medicaid services.

Applies to: Medicaid Managed Care providers (other than an individual practitioner or group of practitioners). Affected providers include, facilities/institutions, ancillary and suppliers. not-for-profit organizations are not excluded from this regulation.

Examples include but are not limited to: hospital, skilled nursing, free standing, home health, independent reference laboratory, ambulance and durable medical equipment providers.

Excluded Providers: Individual practitioner or group of practitioners, any state or federal government provider is excluded from this regulation.

Collection of Provider Disclosure

Disclosure of ownership and control information will be collected at any of the following times:

(1) Upon the provider submitting the provider application

(2) Upon the provider executing the provider agreement

(3) Upon a change in ownership which must be reported within 35 days of the change

Changes in Ownership and Control

Providers must notify us of any changes to their ownership and control within 35 days by completing the Provider Disclosure form. This form can be downloaded from our website, ExcellusBCBS.com/wps/portal/xl/prv/contactus/printforms/.

10.3 Prenatal, Postpartum and Newborn Care

10.3.1 New York State Requirements

Excellus BlueCross BlueShield is obligated by the NYSDOH to have participating providers follow the standards defined by Public Health Law 2522, Subdivision 1, with appropriate detail as defined in accordance with 10 NYCRR § 85.40. The DOH recommends that any pregnant woman who presents for prenatal care should begin receiving care as quickly as possible, preferably the same day.

In March 2015, the DOH revised the NYS Medicaid Prenatal Standards. The standards incorporate evidence-based procedures and practices appropriate to the needs of pregnant women who qualify for Medicaid coverage, regardless of provider or delivery system. They integrate updated standards and guidance from the American College of Obstetrics (ACOG) and the American Academy of Pediatrics (AAP), and reflect expert consensus regarding appropriate care for low income, high-risk pregnant women.

The standards provide a comprehensive model of care that integrates the psychosocial and medical needs, and reflects the special needs of Medicaid population.

The NYSDOH has provided the following contact information to request further information:

- Ambulatory Care Payment Information:
  General Policy, Rates Weights, Carve Out Payment Rules or Implementation Issues:
  518-473-2160 or apg@health.state.ny.us
  APG website:
  www.health.ny.gov/health_care/medicaid/rates/apg/baserates.htm
- Billing, Remittances and Onsite Training: 1-800-343-9000
  Grouper Software, Pricer Product Support, 3M HIS Sales:
  1-800-435-7776 or 1-800-367-2447, or 3mhis.com
- Local Departments of Social Services:
  www.health.ny.gov/health_care/medicaid/ldss.htm
- Prenatal Care Standards Development: Office of Health Insurance Programs, 518-486-6865 or fcg01@health.state.ny.us
- Prenatal Care and Managed Care: Division of Managed Care, Office of Health Insurance Programs, 1-518-473-1134 or omcmail@health.state.ny.us
- Presumptive Eligibility: Medicaid Coverage and Enrollment, Office of Health Insurance Programs, 1-518-474-8887

Excellus BlueCross BlueShield has policies and standards addressing many of the areas listed above, as well as clinical guidelines that address some of the standards specific to obstetrics.

10.3.2 Clinical Guideline for Prenatal and Postpartum Care

Excellus BlueCross BlueShield's guidelines for prenatal and postpartum care is meant to serve as a reference for physicians and health professionals who provide services to pregnant members of Excellus BlueCross BlueShield's programs. (Instructions for accessing guidelines are in the *Quality Improvement* section of this manual.)

Excellus BlueCross BlueShield's prenatal and postpartum guidelines address the following, as well as other care specific to obstetrics:

- Comprehensive risk assessment, including but not limited to genetic, nutritional, psychosocial and historical and emerging obstetrical/fetal and medical/surgical risk factors.
- Nutrition assessment and referral.
- Prenatal diagnostic treatment services and postpartum services, including recommendations for HIV testing and counseling and post-HIV-test counseling.
- Coordination of care between providers of prenatal care and the PCP, pediatrician and other related providers.
- Management and coordination of care for high-risk pregnancies.
- After-hours emergency consultations.
- Postpartum services that include referral to and coordination with a neonatal care provider for pediatric care services.

Medicaid Managed Care Enrollees

Women's Services do not require a referral if the member is in need of or presents with any of the following:

- pregnancy
- OB/GYN services
- family planning services
- midwife services
- breast or pelvic exam

Family Planning Services do not require a referral for the following:

- advice for birth control
- pregnancy tests
- sterilization
- medically necessary abortion

Medicaid managed care members may also choose to see a non-participating provider for family planning services. These services can be billed to Medicaid fee-for-service. Member may contact the NYS Growing Up Healthy Hotline at 1-800-522-5006 for the names of available family planning providers.

In addition to the guidelines mentioned above, Excellus BlueCross BlueShield has established Criteria for Consultation or Transfer of Care to OBGYN for Prenatal Patients at Risk. Both documents are available on the website or from Customer Care.

10.3.3 Medicaid Prenatal Care Medical Record Review

The Medicaid Prenatal Care Medical Record Review process is designed to assess the practitioner's compliance with the NYS Prenatal Standards. A sample of medical records is assessed on an annual basis. To assess the quality of medical record keeping practices, an 80 percent performance goal has been established by Excellus BlueCross BlueShield.

- The Prenatal Standards are based on current medical practice guidelines and reflect requirements put forth by regulatory and accrediting bodies. Standards are assigned points for the purpose of scoring provider compliance.
- A minimum sample of 30 records is reviewed annually for Medicaid members who had a delivery in the six months prior to the review period.
- Comprehensive obstetrical medical records are requested from practitioners and reviewed at Excellus BlueCross BlueShield.
- Annually, aggregate reports of compliance with standards are presented to the Health Care Quality Monitoring Committee (HCQMC) to identify opportunities for improvement. Actions, interventions and follow-up are implemented based on the results of the annual review.

See the *Quality Improvement* section of this manual for additional details.

10.3.4 Newborn Coverage

The newborn child of a Child Health Plus member does not automatically receive health coverage. To enroll the newborn of a Child Health Plus member, the parent or guardian must complete an application. For information about insurance options for the newborn, the parent or guardian may call the Customer Care number on his/her ID card. (For contact information, see the *Contact List* in this manual.)

The newborn child of a HMOBlue Option, Blue Choice Option member may be enrolled in Child Health Plus, HMOBlue Option or Blue Choice Option, depending on the situation. Providers may encourage pregnant women to contact their Medicaid Case Worker at the local Department of Social Services to enroll the unborn child prior to birth. Automatic enrollment does not apply when the mother is enrolled in certain special needs or partial capitation plans, the child will be enrolled in an appropriate special program.

10.4 Early and Periodic Screening, Diagnostic and Treatment

10.4.1 Overview

The federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). It requires that any medically necessary health care service listed at Section 1905(a) of the Social Security Act be provided to an EPSTD recipient, even if the service is not available to the rest of the Medicaid population under the state's Medicaid plan.

The EPSTD manual is available for reference on the NYSDOH website at emedny.org under *Provider Manuals*.

10.4.2 New York's Child Teen Health Program

New York state follows EPSTD guidelines through its Child Teen Health Program (CTHP). Care and services are provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. They generally follow the recommendations of the Committee on Standards of Child Health, American Academy of Pediatrics. The guidelines also emphasize recommendations such as those described in Bright Futures in order to guide health care providers and improve health outcomes for members. CTHP promotes the provision of early and periodic screening services and well care examinations, with diagnosis and treatment of any health or behavioral health and substance use problems identified during these exams.

10.4.3 Clinical Guideline

Excellus BlueCross BlueShield has established clinical guidelines for preventive care as a reference for physicians and other health professionals who provide services to pediatric and adolescent members of its programs. (Instructions for accessing guidelines are in the *Quality Improvement* section, of this manual.)

The clinical guidelines recommend care for infants, children and adolescents in accordance with EPSDT guidelines.

10.4.4 Health Plan and Provider Requirements

Excellus BlueCross BlueShield and its providers must comply with the CTHP program standards and do at least the following for eligible members:

- Educate pregnant women and families with under age 21 enrollees about the program and its importance to a child's or adolescent's health.
- Educate network providers about the program and their responsibilities.
- Conduct outreach, including by mail, telephone, and through home visits (where appropriate), to ensure that children are kept current with respect to their periodicity schedules.

- Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals, and conduct follow-up with children and adolescents who miss or cancel appointments.
- Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a CTHP screen.
- Achieve and maintain an acceptable compliance rate for screening schedules.

The package of services includes administrative services designed to assist families obtain services for children that include outreach, education, appointment scheduling, administrative case management and transportation assistance.

10.5 Vaccines for Children

All providers administering vaccines to children under age 19 covered by HMOBlue Option, Blue Choice Option or Child Health Plus must participate in the New York Vaccine for Children (NYVFC) program. NYVFC provides the vaccines free of charge. For more information about VFC and how to obtain vaccines, providers should call VFC directly. The eligible vaccines are listed on the Centers for Disease Control and Prevention website. (The telephone number for NYVFC and the website for the CDC VFC program are included on the *Contact List* in this manual.) See the *Billing and Remittance* section of this manual for information about submitting claims.

10.6 Vision Care

Because members of government programs do not need a referral or preauthorization to access vision care services, it is very important for practitioners who provide vision care services to check eligibility and benefits by calling Customer Care. Benefit limitations and other requirements vary among the government programs. Member eligibility for covered services will be based on the information the provider supplies to Customer Care at the time of the call and on the member's current benefit history.

10.6.1 Covered Services

Routine Eye Exams

Medicaid managed care (Blue Choice Option, HMOBlue Option and Blue Option Plus/Premier Option Plus) members are eligible for one routine eye examination every 24 months. Child Health Plus members may have one routine eye exam every 12 months. These limitations apply only to routine eye exams such as routine visual acuity or refraction tests. They do not apply to non-routine tests for individual with conditions such as diabetes that can affect the vision.

Lenses and Frames

The benefit for government program members is limited to medically necessary basic lenses and frames. This includes bifocal or trifocal lenses when medically necessary. It does not include contact lenses (see *Exclusions*, below).

Medicaid managed care (Blue Choice Option, HMOBlue Option and Blue Option Plus/Premier Option Plus members are eligible to receive one set of basic lenses and frames every 24

months. Child Health Plus members are eligible to receive one set of basic lenses and frames every 12 months. **Participating providers must have a selection of frames available that are within the allowed amount.**

If medically necessary, Medicaid managed care (Blue Choice Option, HMOBlue Option and Blue Option Plus/Premier Option Plus and Child Health Plus members may be eligible to receive an additional pair of glasses within the benefit time frames.

10.6.2 Exclusions

Excellus BlueCross BlueShield does not cover:

- Routine exams and lenses/frames that are beyond the limitations stated above.
- Lenses/frames from practitioners who have not agreed to accept Excellus BlueCross BlueShield's allowance (in other words, do not participate in the government program network).
- Safety glasses.
- Added features such as progressive lenses, anti-reflective coatings, photosensitive, tints, transition lenses or other specialty lenses, unless determined medically necessary.
- Contact lenses, unless determined medically necessary (See the Medical Policy *Contact Lenses for Medicaid, Child Health Plus Contracts* available on Excellus BlueCross BlueShield's website or from Customer Care.) The prescribing vision care provider must obtain prior approval and submit a letter of medical necessity to Excellus BlueCross BlueShield. The letter must include a diagnosis and the member's medical history.

10.6.3 Upgrades

Medicaid managed care

Excellus BlueCross BlueShield does not permit vision allowance upgrades for members of Medicaid managed care (HMOBlue Option/Blue Choice Option, Blue Option Plus/Premier Option Plus) Excellus BlueCross BlueShield will reimburse a vision care provider only if he/she dispenses basic frames and/or basic lenses to a HMOBlue Option/Blue Choice Option or Blue Option Plus/Premier Option Plus member.

The practitioner must inform the member that the benefit is only for basic frames and lenses. If the member selects lenses other than basic lenses and/or a frame that exceeds the allowance, the practitioner must collect the full cost of those items directly from the member.

However, if the upgrade is for only the lenses or only the frames, Excellus BlueCross BlueShield will reimburse the provider for whichever component is basic (lenses or frames). The member is responsible for the full cost of the upgraded component.

Child Health Plus

Child Health Plus members may choose to upgrade at their own expense and Excellus BlueCross BlueShield will reimburse the practitioner at the allowance for basic frames and/or lenses. **This does not mean that the member may choose contact lenses instead of eyeglasses.** (See *Exclusions*, above.) If the member selects lenses other than basic lenses and/or a frame that exceeds the allowance, the practitioner must collect the balance directly from the member.

10.6.4 Replacement and Repair of Lenses and Frames

Excellus BlueCross BlueShield's coverage for Medicaid managed care and Child Health Plus members includes the replacement of lost or destroyed eyeglasses, if appropriately documented. The replacement of eyeglasses must duplicate the original prescription and frame.

10.7 Medicaid Managed Care Institutional Long-Term Care Mandate

A New York state mandate provides eligible Medicaid managed care members (HMOBlue Option, Blue Choice Option and Premier Option and Blue Option Plus/Premier Option Plus products) age 21 or older with institutional long-term care.

- The member's physician must verify the member's eligibility for institutional long-term care on our website at ExcellusBCBS.com/ProviderCoverageClaims, or by calling Customer Care at 1-800-920-8889.
- If the member is eligible for institutional long-term care, the member's physician must submit a recommendation to Excellus BlueCross BlueShield by calling Customer Care.
- Prior authorization for institutional long-term care placement must be obtained by calling Customer Care.
- Documentation is submitted by the institutional long-term care facility to the local Department of Social Services within 90 days of the date of long-term care placement.

Medical claims for Medicaid managed care members who are newly admitted to institutional long-term placement with dates of service on or after July 1, 2015, should be submitted using revenue codes 100, 101, 124, 160, 183, 185, 189, or 199. Revenue code 663 replaces revenue code 660 for respite care. As with all covered services, our utilization management policies and procedures apply.

If a member is using a prescription drug that requires prior authorization, step therapy, is non-formulary, or has a quantity limits, we must allow the member to continue receiving the drug for 60 days. These members will receive a transition letter to notify them that future fills of that drug will require prior authorization.

To view our tip sheet for institutional long-term care placement of Medicaid managed care members, visit ExcellusBCBS.com/ProviderEducation.

10.8 HIV Care

Excellus BlueCross BlueShield recommends that providers follow the HIV guidelines established by the NYSDOH AIDS Institute. These guidelines pertain to prevention and medical management of adults, children, and adolescents with HIV infection. These guidelines are available at the NYSDOH AIDS Institute website, hivguidelines.org. Providers

may also refer to the discussion of NYSDOH requirements for HIV Counseling, Testing and Care of HIV Positive Individuals in the *Quality Improvement* section of this manual.

Individuals may obtain HIV information and referrals by calling the NYSDOH's Anonymous HIV Counseling and Testing Program at 1-800-541-AIDS.

10.9 Personal Care Services

Personal care services are a benefit for Medicaid members only. Services are defined as some or total assistance with personal hygiene, dressing, feeding, nutritional and environmental support functions. Services must be essential to the maintenance of the patient's health and safety in his/her own home, as determined by the social services district, or its designee, in accordance with the regulations of the New York State Department of Health (NYSDOH). All agencies providing personal care services must be licensed or certified to operate as a home care agency by the NYSDOH and must participate in the Excellus BlueCross BlueShield provider network. Services must be prior authorized. See: "Personal Care Aide (PCA) and Consumer Directed Personal Assistant (CDPA) Services for Medicaid Managed Care Contracts" medical policy for medical criteria.

10.10 Health Home

The Medicaid Health Home program provides reimbursement for care management to approved Health Home providers for the services listed below:

- care coordination and health promotion
- comprehensive care management
- transitional care from inpatient to other settings, including follow-up
- individual and family support, which includes authorized representatives
- referrals to community and social support services
- use of health information technology to link services

These services are provided to enrollees with behavioral health and/or chronic medical conditions who are determined eligible for Health Home services

Excellus BlueCross BlueShield has assigned a single point for each Health Home and that point of contact will communicate protocols with each Health Home's single point of contact.

Excellus BlueCross BlueShield collaborates with Health Homes and network PCPs to establish consistent BH screening for all members, with particular focus on those with high-risk medical conditions including, but not limited to, tobacco use disorder, stroke, myocardial infarction, cancer, HIV, and chronic pain. Excellus BlueCross BlueShield screening activities will especially screen for depression, anxiety, and substance use disorders.

Health Homes and PCPs will screen all individuals, including those with the above high-risk medical conditions using screening tools such as the PHQ-9 for depression, CAGE and SBIRT models for substance use, the GAD 7 for anxiety and the Life Event Checklist for trauma, or similar state-approved screening tools. Adoption and deployment of these screening tools will be done in collaboration with the Health Homes in support of their efforts toward integration of behavioral health and primary care.

10.11 HARP Care Recovery Model

HARP is a care recovery model that emphasizes and supports a member's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance disorders through empowerment, choice, treatment, educational, vocational, housing, and health and well-being goals. HARP is a managed care product that manages physical health, mental health and substance use services in an integrated way for adults with significant behavioral health needs (MH/SUD). HARPs must be qualified by New York state and must have specialized expertise, tools and protocols.

As of July 1, 2016, we implemented a HARP plan for eligible members, and began managing certain behavioral health services that carved into the Medicaid managed care service model for eligible members 21 and over. We provide members who qualify with all of the standard Medicaid benefits, along with comprehensive care management, access to Health Homes, as well as certain enhanced behavioral health services commonly referred to as Home and Community Based Services (HCBS). For additional information, visit the New York State's Office of Mental Health's website at http://www.omh.ny.gov/omhweb/bho/.

10.12 Personal Emergency Response System (PERS)

The Medicaid PERS assessment is completed simultaneously with the nursing assessment for personal care. Services that are deemed medically necessary will be reimbursed monthly. All PERS services must be provided by an Excellus BlueCross BlueShield-designated agency.

Preauthorization Requirements

All PCA/CDPAS services and PERS requests including nursing assessments and supervision must receive preauthorization to be eligible for reimbursement. Call Customer Care at 1-800-920-8889.

Claim Submission

Excellus BlueCross BlueShield
PO Box 22999
Rochester, NY 14692

10.13 Sterilization Procedures

Important: Sterilization procedures, whether incidental to maternity or not, require completion of a patient consent form in accordance with Medicaid guidelines covering informed consent procedures for Hysterectomy and Sterilization specified in 42 CFR, Part 441, sub-part (F), and 18NYCRR Section 505.13 and with applicable EPSDT requirements specified in 42 CFR, Part 441, sub-part (B), 18NYCRR, Part 508.

10.13.1 Informed Consent for Sterilization

Patients must be at least 21 years of age at the time of informed consent and mentally competent, and they must complete and sign LDSS-3134, *Sterilization Consent Form,* at least 30 days, but not more than 180 days prior to a bilateral tubal ligation or vasectomy procedure, or any other medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of having a child.

"Informed consent" means that:

- The patient gave consent voluntarily after the provider planning to perform the procedure has:
  - Offered to answer any questions;
  - Told the patient that he or she is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting his or her right to future care or treatment and without loss or withdrawal of any of his or her federally-funded benefits;
  - Told the patient that there are alternative methods of family planning and birth control;
  - Told the patient that the sterilization procedure is considered to be irreversible;
  - Explained the exact procedure to be performed on the patient;
  - Described the risks and discomforts the patient may experience including effects of any anesthesia;
  - Described the benefits and advantages of sterilization; and
  - Advised the patient that the sterilization will not be performed for at least 30 days following the informed consent, and
- The provider planning to perform the procedure:
  - Has made arrangements so that the above information was effectively communicated to a blind, deaf or otherwise disabled person;
  - Provided an interpreter if the patient did not understand the language on the consent form or the person who obtained informed consent; and
  - Permitted the patient to have a witness present when consent was given.

10.13.2 Hysterectomy

Hysterectomy is covered only in cases of medical necessity and not solely for the purpose of sterilization. Patients must be informed that the procedure will render them permanently incapable of reproducing. A patient must complete LDSS-3103, *Acknowledgement of Receipt of Hysterectomy Information*, at least 30 days prior to the procedure. Prior acknowledgment may be waived when a woman is sterile prior to the hysterectomy or in life-threatening emergencies where prior consent is impossible.

10.13.3 Submission of Forms Required for Payment

The performing provider must send a copy of the completed *Sterilization Consent Form* or *Acknowledgement of Receipt of Hysterectomy Information* form to Excellus BlueCross BlueShield either prior to submitting a claim for the procedure or with the claim for the procedure. Excellus BlueCross BlueShield will deny payment for sterilization procedures or hysterectomy if the physician fails to submit evidence of informed consent given within the required time frames noted in the preceding paragraphs.

10.13.4 Where to Get Forms

Providers must request blank forms, *Sterilization Consent Form* or *Acknowledgment of Receipt of Hysterectomy Information*, from the NYSDOH by completing a *Request for Forms or Publications* form and faxing or mailing it to the NYSDOH. For contact information, see *Sterilization and Hysterectomy Consent Forms* on the *Contact List* in this manual.

10.14 Submitting Claims to Excellus BlueCross BlueShield

Submit claims for government programs to Excellus BlueCross BlueShield using the same method as claims for other health benefit programs — electronically or on paper. Information about billing and reimbursement is included in the *Billing and Remittance* section of this manual. The address for paper claim submittal is on the *Contact List* in this manual.

10.15 Member Payments – Medicaid F

The following sections are a direct reprint from the April 2006 NYSDOH *Medicaid Update*. The update is a reminder to all hospitals, freestanding clinics and individual practitioners about requirements of the Medicaid program related to requesting compensation from Medicaid recipients, including Medicaid recipients who are enrolled in a Medicaid managed care plan. Providers may collect applicable copayments, but may not deny treatment if the member does not have the copayment at the time.

10.15.1 Acceptance and Agreement

When a provider accepts a Medicaid recipient as a patient, the provider agrees to bill Medicaid for services provided or, in the case of a Medicaid managed care enrollee, agrees to bill the recipient's managed care plan for services covered by the contract.

- The provider is prohibited from requesting any monetary compensation from the recipient, or his/her responsible relative, except for any applicable copayments.
- A provider may charge a Medicaid recipient, including a Medicaid managed care recipient enrolled in a managed care plan, **only** when both parties have agreed **prior to the rendering of the service** that the recipient is being seen as a private pay patient.
- This agreement must be mutual and voluntary.

It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient record.

A *provider who participates in Medicaid fee-for-service* may not bill Medicaid fee-for-service for any services included in a recipient's managed care plan, with the exception of family planning services, *when the provider does not provide such services under a contract with the recipient's health plan.*

A provider who does not participate in Medicaid fee-for-service, but who has a contract with one or more managed care plans to serve Medicaid managed care members **may not bill Medicaid fee-for-service** for any services. Nor may any Excellus BlueCross BlueShield non-participating provider bill a recipient for services that are covered by the recipient's Medicaid managed care contract, unless there is prior agreement with the recipient that he/she is being seen as a private patient as described above. *The provider must inform the recipient that the services may be obtained at no cost to the recipient from a provider that participates in the recipient's managed care plan.*

10.15.2 Claim Submission

The prohibition on charging a Medicaid recipient applies:

- when a participating Medicaid provider or a Medicaid managed care participating provider fails to submit a claim to Computer Sciences Corporation (CSC) or the recipient's managed care plan within the required time frame; or
- when a claim is submitted to CSC or the recipient's managed care plan, and the claim is denied for reasons other than that the patient was not eligible for Medicaid on the date of service.

10.15.3 Collections

A Medicaid recipient, including a Medicaid managed care enrollee, **must not be referred to a collection agency** for collection of unpaid medical bills or otherwise billed, *except for applicable copayments*, **when the provider has accepted the recipient as a Medicaid patient.**

Providers, however, may use any legal means to collect applicable unpaid copayments.

10.15.4 Emergency Medical Care

A hospital that accepts a Medicaid recipient as a patient, including a Medicaid recipient enrolled in a managed care plan, accepts the responsibility of making sure that the patient receives all medically necessary care and services.

Other than for legally established copayments, a Medicaid recipient **should never be required to bear any out-of-pocket expenses** for:

- medically necessary inpatient services; or,
- medically necessary services provided in a hospital-based emergency room (ER).

This policy applies regardless of whether the individual practitioner treating the recipient in the facility is enrolled in the Medicaid program.

When reimbursing for ER services provided to Medicaid managed care enrollees, health plans must apply:

- The Prudent Layperson Standard;

- Provisions of the Medicaid Managed Care Model Contract; and,
- Health Department directives.

10.15.5 Claim Problems

If a problem arises with a claim submission for services covered by Medicaid fee-for-service, the provider must first contact CSC. If the claim is for a service included in the Medicaid managed care benefit package, the enrollee's managed care plan must be contacted. If CSC or the managed care plan is unable to resolve an issue because some action must be taken by the recipient's local department of social services (e.g., investigation of recipient eligibility issues), the provider must contact the local department of social services for resolution.

For questions regarding Medicaid managed care, please call the Office of Managed Care at 518-473-0122. For questions regarding Medicaid fee-for-service, please call the Office of Medicaid Management at 518-473-2160.

10.16 Member Grievance/Complaints and Utilization Review Appeal Policy and Procedure

> **Note:** The following guidelines apply to members of HMOBlue Option, Blue Choice Option and Blue Option Plus/Premier Option Plus They do not, however, apply to members in the Child Health Plus health benefit program. (See the *Benefits Management* section of this manual for procedures for Child Health Plus members.)

Excellus BlueCross BlueShield encourages all members to voice both positive and negative comments regarding care and services they have received. All member concerns are documented at the member's request, and Excellus BlueCross BlueShield responds in a timely manner. If a member has a concern that cannot be resolved immediately on the telephone, Excellus BlueCross BlueShield informs the member of the right to file a formal Level 1 Grievance or to designate a representative to file a Level 1 Grievance on the member's behalf. Excellus BlueCross BlueShield describes these rights in the member handbook.

In no event will Excellus BlueCross BlueShield retaliate or take any discriminatory action against a member because the member has filed a grievance.

Excellus BlueCross BlueShield endeavors to make the grievance procedure accessible to non-English speaking members. Upon request, Excellus BlueCross BlueShield will provide a written copy of the grievance procedure, readable at a fourth grade level.

This section 10.15.1 addresses:

- The review of issues (including quality of care and access to care complaints) not associated with medical necessity or experimental/investigational determination (grievances).
- The review of issues that involve a medical necessity or experimental/investigational determination (appeals).

10.16.1 Medicaid Grievance Procedure

A. Level 1 Grievance

1. A member or a member's representative may call Customer Care or come in person to register a Grievance. (See Member Grievances on the *Contact List* in this manual.) Alternatively, a member or a member's representative may submit a Grievance in writing to the Customer Care department at Excellus BlueCross BlueShield address listed on the *Contact List*. Grievances must be filed within 60 business days of the initial determination.

   If the grievance was filed orally, an Advocacy Associate will document a summary of the grievance on a complaint form and submit the form to the member for signature, with the exception of expedited cases. Investigation of the grievance will continue during this process.

2. Customer Care representatives are available to document the member's grievance during regular business hours. After regular business hours and on weekends, the member may leave a message for Customer Care on the voice mail system by calling the after-hours number listed under Member Grievances on the *Contact List* in this manual. If a member leaves a message or submits a grievance in writing, a Customer Care representative will telephone the member to verify receipt of the grievance. The representative will contact the member on the next business day after receipt of the oral or written grievance.

3. An Advocacy Associate records the member's grievance and initiates a thorough review.

4. Time frames for response to a Level 1 Grievance

   a) Within 15 calendar days of receipt of the Level 1 Grievance, an Excellus BlueCross BlueShield representative will send the member a written acknowledgment, including the name, address and telephone number of the individual or department handling the Level 1 Grievance. This acknowledgment will inform the member of the status of the Level 1 Grievance and advise whether any additional information is required for Excellus BlueCross BlueShield to process the Level 1 Grievance.

   b) Additional required information may include, but is not limited to such items as medical records, a chronology of events, or legal documents related to the Level 1 Grievance.

   c) Once Excellus BlueCross BlueShield has received all necessary information, it will resolve the Level 1 Grievance on the following schedule:

      (1) **Within two business days** when a delay would significantly increase the risk to the member's health **(Expedited Level 1 Grievance)**. Excellus BlueCross BlueShield will notify the member of its decision by telephone within two business days, with a written notice to follow within 24 hours after the determination.

(2) **Within 30 calendar days** in the case of non-urgent requests for referrals or disputes involving covered benefits.

(3) **Within 60 calendar days** in all other instances.

5. Level 1 Grievance Determination
   a) Appropriate administrative staff will decide the Level 1 Grievance.
   b) If the Level 1 Grievance relates to a clinical matter, the reviewer will be, or will consult with, a licensed, certified or registered health care professional.
   c) Excellus BlueCross BlueShield will notify the member in writing of the determination. The notice will include detailed reasons for the determination, the clinical rationale, if applicable, the procedures and form for filing.

B. Fair Hearings

Medicaid members may also request a fair hearing from New York state whenever Excellus BlueCross BlueShield denies a request for medical services. Contact information for requesting a fair hearing is included on the *Contact List* in this manual.

C. Investigation and Documentation of Level 1 Grievances

1. Research/Investigation. All Level 1 Grievances are investigated thoroughly. The research/investigation phase includes but is not to the following interventions:
   a) Contact with appropriate provider and/or supervisor for intervention.
   b) Review written records to gather information.
   c) Obtain responses from appropriate staff as necessary.
   d) Contact with Quality Assurance staff for all concerns regarding quality of care and treatment issues.
2. Documentation. All Level 1 Grievances are documented.
   a) All research/investigative activities and results are documented by the Advocacy Associate on the Grievance database.
   b) Documentation includes the names of the individuals who have been contacted for intervention or for informational purposes regarding the Level 1 Grievance.
   c) Any action taken and communication with a member is also documented on the database. The final resolution will include information received in the research phase and any additional explanatory information that will assist the member in his/her understanding of Excellus BlueCross BlueShield's system.

D. Records

The Advocacy Unit maintains a file on each Grievance that includes the following:

1. Level 1 Grievance
   a) The date Excellus BlueCross BlueShield received the Level 1 Grievance.
   b) Documentation compiled by the Advocacy Associate relating to the Level 1 Grievance.

c) The date of and a copy of the acknowledgment sent to the complainant.

d) A copy of the response to the Level 1 Grievance, including the date of determination and the titles and/or credentials of the personnel who reviewed the Level 1 Grievance.

F. Intangible Grievances

Intangible grievance includes the following categories:

Clinical Quality of Care. A clinical quality concern is one that may adversely affect the health and/or well-being of the member. Examples of this may include perceptions of inadequate or inappropriate treatment or failure to diagnose accurately.

Access to Care. Inability to obtain a timely appointment or after-hours appointment availability.

Interpersonal Issues. Interpersonal issues with a provider or their office staff or other complaints against the corporation.

G. Record/Information Request Process

In cases where additional information is deemed necessary, the following guidelines will apply.

For standard appeals and grievances:

- Excellus BlueCross BlueShield will identify and request information **in writing** from the member and provider within 5 business days of receipt of the incomplete information, stating what information must be supplied.

  For intangible complaints, if additional information if not received, Excellus BlueCross BlueShield will send a statement in writing that the determination could not be made and the date the additional information time frame expires.

For expedited appeals and grievances:

- Excellus BlueCross BlueShield will expeditiously identify and request information via **phone or fax** to the member and provider followed by written notification to the member and provider.

10.16.2 Medicaid Utilization Review Appeal Procedure

A member may appeal adverse determinations related to medical necessity and experimental or investigational denials. The Advocacy Unit is responsible for appeals of utilization review determinations. An Advocacy Associate will prepare and present all appeals to a Medical Director who was not involved in the initial determination. Where necessary, the Advocacy Associate will obtain a Clinical Peer Review for the Medical Director's consideration. For information related to utilization review notification and determination time frames, visit our website, ExcellusBCBS.com/Provider, for a chart titled *UM Initial Determination Time Frames - Medicaid and Safety Net Products.*

A. Definition

For purposes of this policy, a Clinical Peer Reviewer means:

1. A physician who possesses a current and valid non-restricted license to practice medicine; or
2. A health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certificate or registration, or where no provision for a license, certificate or registration exists, and is credentialed by the national accrediting body appropriate to the profession.
3. For behavioral health decisions, peer-to-peer reviews must include a physician who is board-certified in general psychiatry for review of all inpatient level of care denials for psychiatric treatment. A physician certified in addiction treatment must review all inpatient level of care denials for substance use disorder (SUD) treatment.

B. Procedure

A member, the member's designee and, in connection with retrospective determinations, a member's health care provider, may appeal an Adverse Determination rendered by Excellus BlueCross BlueShield through the internal appeal process described below.

1. The member has the right to designate a representative to assist him/her in the appeal process. The member must contact Customer Care either verbally or in writing to appoint a representative.
2. The member has 60 business days after receiving notice of an initial adverse determination to request an appeal.
3. If the appeal was filed orally, an Advocacy Associate will document a summary of the appeal on a complaint form, with the exception of expedited cases and submit the form to the member for signature. Investigation of the appeal will continue during this process.
4. The member has the right to present evidence (within a limited time stated by Excellus BlueCross BlueShield) and allegations of fact or law, in person as well as in writing. The member or his or her designee, both before and during the appeal process, may examine the member's case file, including medical records and any other documents and records considered during the appeal process.

C. Time Frames

1. Expedited Appeals

a) In any case except one involving retrospective review, an expedited appeal may be available if:

(i) The adverse determination involves continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider; or

(ii) The health care provider believes an immediate appeal is warranted.

(iii) If an expedited appeal is requested but we determine that it does not meet the conditions described above, we will notify the member verbally and in writing within two days that the expedited appeal has been declined,

however, we will immediately initiate a standard appeal.

b) A Clinical Peer Reviewer other than the Clinical Peer Reviewer who rendered the initial adverse determination will review the appeal. Excellus BlueCross BlueShield will provide reasonable access to its Clinical Peer Reviewer within one business day of receiving notice of the taking of an expedited appeal.

c) Excellus BlueCross BlueShield will decide the expedited appeal and notify the member and his/her health care provider of the determination as expeditiously as possible, but no later than **three business days** after receipt of the appeal or **two business days** after receipt of all necessary information, whichever is less, with the exception of concurrent substance use review, which will be handled within 24 hours of receipt. If Excellus BlueCross BlueShield fails to make a determination within these time frames, the request will be deemed approved. The time frame for a determination may be extended for up to 14 days upon member or provider request, or if Excellus BlueCross BlueShield demonstrates (and notifies the member) that additional information is needed and that the delay is in the best interest of the member. If Excellus BlueCross BlueShield requires additional necessary information to conduct the appeal, we will notify the member or the member's designee and the member's health care provider immediately, by telephone or facsimile, to identify and request the necessary information, followed by written notification.

d) Excellus BlueCross BlueShield will make reasonable effort to provide oral notice of the determination to the enrollee and provider at the time the determination is made. Excellus BlueCross BlueShield will provide written confirmation of the decision within two business days of the determination. If Excellus BlueCross BlueShield upholds the initial adverse determination, the written confirmation will be a final adverse determination.

(i) The final adverse determination will include the specific reasons and clinical rationale for the denial, information about further appeal rights such as a standard after expedited appeal, and an explanation of the member's right to external review, if applicable. An external appeal form will be sent with the notice of final adverse determination

(ii) If an external appeal is available, the member has 45 days after receiving the final adverse determination to file an external appeal.

2. Standard Appeals

When an expedited appeal is not available, or if the member is not satisfied with the result of the expedited appeal, the member has the right to a standard appeal. Excellus BlueCross BlueShield will decide the standard appeal and notify the member or his/her designee **within 30 calendar days** of receipt of the appeal. Written notice of the determination will be provided to the member (and member's provider if he/she requested the review) within two business days after the determination is made. The time frame for a determination may be extended for up to 14 days upon member or provider request, or if Excellus BlueCross BlueShield demonstrates (and notifies the member) that additional information is needed and that the delay is in

the best interest of the member.

a) Excellus BlueCross BlueShield will send the member an acknowledgment of his/her appeal within fifteen calendar days, indicating the address and telephone number of the person or department responsible for rendering a decision. If Excellus BlueCross BlueShield requires additional necessary information to conduct the appeal, we will notify the Member or the Member's designee and the Member's health care provider, in writing, within fifteen calendar days of receipt of the appeal, to identify and request the necessary information.

b) A Clinical Peer Reviewer other than the Clinical Peer Reviewer who rendered the initial Adverse Determination will review the appeal.

c) If Excellus BlueCross BlueShield fails to make a determination within 30 calendar days after receipt of all necessary information, the request will be deemed approved, unless an extension has been requested.

d) The notification will include reasons for the determination, and if the initial Adverse Determination is upheld, the clinical rational for the determination.

e) If the initial denial is upheld, Excellus BlueCross BlueShield will issue the member and/or the member's health care provider a notice of Final Adverse Determination, along with information about further appeal rights and the member's right to external review, if applicable.

f) If an external appeal is available, the member has four months after receipt of the Final Adverse Determination to file an external appeal.

g) Each notice of a Final Adverse Determination of an expedited or standard utilization review appeal will be in writing, dated and include the following:

   i. A clear statement describing the basis and clinical rationale for the denial.
   ii. A clear statement that the notice constitutes a final adverse determination and that specifically uses the terms "medical necessity" or "experimental/investigational."
   iii. A summary of the appeal, and the date the appeal was filed.
   iv. The date the appeal process was completed.
   v. Excellus BlueCross BlueShield's contact person and his or her telephone number.
   vi. The member's coverage type.
   vii. The name and full address of the Excellus BlueCross BlueShield's utilization review agent.
   viii. The utilization review agent's contact person and his or her telephone number.
   ix. A description of the health care service that was denied, including, as applicable and available, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service.
   x. A statement that the member may be eligible for an external appeal and the time frames for requesting an appeal.

xi. A copy of "Standard Description and Instructions for Health Care Consumers to Request an External Appeal."

xii. A clear statement written in bolded text that the 45-day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the member to request an external appeal.

xiii. Right of the member to complain to the NYSDOH at any time, including toll-free phone number.

xiv. Description of member's fair hearing rights (see below).

xv. A statement that the notice is available in other languages and formats for special needs and how to access these formats.

3. Fair Hearing

Medicaid members may request a fair hearing if Excellus BlueCross BlueShield denies coverage. The member may request a fair hearing from the state and still file an external appeal, or vice versa. In some cases, the member may be able to continue to receive the terminated, suspended or reduced services until the fair hearing is decided. If the Member asks for both a fair hearing and an external appeal, the decision of the Fair Hearing Office will control. See below for additional information.

4. Waiving Internal Appeal Process

If the member and Excellus BlueCross BlueShield jointly agree to waive the internal appeal process, Excellus BlueCross BlueShield must provide a written letter agreeing to the waiver within 24 hours of the agreement to waive its internal appeal process.

D. Record Request Process

In cases where additional information is deemed necessary, the following guidelines will apply.

For standard appeals and grievances: Excellus BlueCross BlueShield will identify and request information **in writing** from the member and provider within the applicable case time period but no later than 15 calendar days of receipt of the request.

For expedited appeals and grievances: Excellus BlueCross BlueShield will expeditiously identify and request information via **phone or fax** to the member and provider followed by **written notification** to the member and provider.

E. External Appeal

A member, the member's designee and, a member's health care provider, may request in conjunction with a concurrent or retrospective appeal an adverse determination rendered by Excellus BlueCross BlueShield through the external appeal process. Only a member or the member's designee may file in conjunction with a pre-service determination. An external appeal must be submitted within 60 days (for a provider) of receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested.

An external appeal may be filed when:

1. the member has had coverage of a health care service, that would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the ground that such health care service is not medically necessary, **and**
2. Excellus BlueCross BlueShield has rendered a final adverse determination with respect to such health care service, **or**
3. both Excellus BlueCross BlueShield and the member have jointly agreed to waive any internal appeal.

An external appeal may also be filed:

1. When the member has had coverage of a health care service denied on the basis that such service is experimental or investigational, **and**
2. the denial has been upheld on appeal **or** both Excellus BlueCross BlueShield and the member have jointly agreed to waive any internal appeal
3. **and** the member's attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health care services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by Excellus BlueCross BlueShield or (c) for which there exists a clinical trial.
4. **and** the member's attending physician, who must be a licenses, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must have recommended either (a) a health service or procedure that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. The physician certification mentioned above will include a statement of the evidence relied upon by the physician in certifying his/her recommendation,
5. **and** the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

An external appeal may also be filed:

6. if a health service is out-of-network and an alternate recommended treatment is available in-network, and the health plan has rendered a final adverse determination with respect to an out-of-network denial.

7. and the insured's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, certifies that the out-of-network health service is materially different than the alternate recommended in-network health service, and recommends a health service that, based on two documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment.

8. The insured has had an out-of-network referral denied on the grounds that the health care plan has a health care provider in the in-network benefits portion of its network with

appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service.

A member or the member's designee may request a fair hearing and ask for an external appeal. If both a fair hearing and an external appeal are requested, the decision of the fair hearing officer will be the one that counts.

A standard appeal or an external appeal may be filed after an expedited appeal determination has been upheld. If a standard appeal is requested and the Health Plan upholds its decision, you will receive a new final adverse determination and have another chance to ask for an external appeal.

Additional appeals to the Health Plan may be available to the member or member designee if they wish to use them. However, if the member or member designee wants an external appeal, they will lose their right to an external appeal if they do not file an external appeal application within the filing time frame.

10.16.3 Fair Hearing

In addition to the grievance and appeal guidelines outlined above, a member of HMOBlue Option, Blue Choice Option or Blue Option Plus/Premier Option Plus may request a fair hearing regarding adverse determinations concerning enrollment, disenrollment and eligibility; and regarding the denial, termination, suspension or reduction of a clinical treatment or other benefit package service. This hearing allows the member to present his/her case in person and ask the attendees questions regarding the member's case.

Fair hearing rights and the related form are included with member notices of final adverse determinations.

If the member believes that an action taken by Excellus BlueCross BlueShield is wrong, he/she can ask for a fair hearing by telephone or in writing. (See *Contact List* in this manual.)

The member must ask for a fair hearing within 60 days from the date noted on the *Denial of Benefits under Managed Care Notice*. Once the fair hearing is requested, the State will send the member a notice with the time and place of the hearing. The member has the right to bring a person to help, such as a lawyer, a friend, a relative, or someone else. At the hearing, this person can give the hearing office something in writing or just orally state why the action should not be taken. This person can also ask questions of any other people at the hearing. The member also has the right to bring people to speak in his/her favor. If the member has any papers that will help his/her case (pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc.), he/she should bring them.

The member has the right to see his/her case file to help get ready for the hearing. The member may call or write to the NYS Office of Temporary and Disability Assistance, Fair Hearing Section, (as listed under fair hearings on the *Contact List*). The Office of Temporary and Disability Assistance will give the member—and the hearing officer— free copies of the documents from the member's file. The member should ask for these documents before the date of the hearing. The documents will be provided to the member within a reasonable time before the date of the hearing. Documents will be mailed only if the member requests that they be mailed.

The member has the right to request continuation of benefits while the fair hearing is pending. If Excellus BlueCross BlueShield's action is upheld at the hearing, the member may be liable for the cost of any continued benefits.