# 2019 Provider and Facility Reference Manual

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The information in this manual applies to all lines of business, unless otherwise noted.

Be advised that information may change as a result of regulatory updates or mandates.
Section 1 – About BlueCross BlueShield

BlueCross BlueShield of Western New York is one of many individual BlueCross and BlueShield Plans in the United States. In addition to our Buffalo-based Plan, our parent company, HealthNow New York Inc., operates two other divisions:

- BlueShield of Northeastern New York, based in Albany
- HealthNow Administrative Services (HNAS), located in Blue Bell, PA

For the convenience of our participating BlueCross BlueShield of Western New York providers, we have developed this manual, which includes all the information you will need regarding:

- The health care products we offer
- The services we provide to physicians and members
- Our policies and procedures
- Claims information
- Provider reimbursement

There will be periodic updates to this manual. We hope you will find this manual to be a helpful reference tool.

Vision and Mission Statements

BlueCross BlueShield is committed to working with our participating physicians to ensure members receive quality, cost-effective health care services. To this end, we have adopted the following vision and mission statements:

Our Vision: To be the preferred health care plan for our communities.

Our Mission: To develop and provide innovative and cost-effective health care delivery solutions to support the needs of our members, stakeholders, and communities.

BlueCross BlueShield offers a wide variety of managed care and traditional products to groups and individuals. We are dedicated to providing members with quality health care that is cost-effective and easy to access.

Quality Management

BlueCross BlueShield’s Quality Management programs are designed to ensure that members have access to the care and services they need with the ultimate goal of improving the health care and services provided to our members.

BlueCross BlueShield’s efforts to provide quality care to our managed care members have been recognized by accreditation through the National Committee for Quality
Assurance (NCQA), a non-profit organization that has established an accreditation system to evaluate health plans across the nation.

**Access to Care**

To ensure members have appropriate access to care, we contract with hospitals and physicians in our operating area. Physicians who participate with our managed care programs are required to be available 24 hours per day, seven days per week. If the physician is unavailable, he or she is responsible for making on-call coverage arrangements with other participating physicians.

BlueCross BlueShield has taken steps to reduce hospital and medical expenses without compromising access to or quality of care. A few of these initiatives are listed here. Complete details about these and other Utilization Management initiatives can be found in this Physician Manual.

- Our Utilization Management Department streamlines the preauthorization and facility review functions into one unit. This provides better service and a more personal touch for our physicians.

- Our Case and Disease Management Department follows a member-focused program that facilitates a plan of care that is developed with a physician’s orders.

- Patient-Centered Medical Home (PCMH) is a voluntary program for primary care physicians (adult and pediatric) that recognizes high-performing practices in key areas of clinical quality and care coordination. PCMH is sponsored by the National Committee for Quality Assurance (NCQA) – a private, not-for-profit organization dedicated to improving our nation’s health care quality.

- Implementing the use of a managed care prescription drug formulary to improve the value of pharmaceutical care delivered through proper consideration of both quality of care and economic issues.

Our Access to Care policy for physician appointments is established for PCP, Behavioral Health, and OB-GYN care to ensure BlueCross BlueShield members’ timely accessibility to health and behavioral care services. Practitioners are required to follow the Access to Care policy available on our provider website.

**The Physician’s Role in Managed Care: The Primary Care Physician**

Managed care members are required to select a primary care physician (PCP) from our directory of participating providers. The PCP is responsible for monitoring his or her patients and coordinating the delivery of all health care services, including preventive and routine medical care, hospitalization, and specialized care within the network.
enrollee is using behavioral health clinic that also provides primary care services, enrollee may select lead provider to be PCP.

Members are instructed to contact their PCP before seeking medical treatment, except in the case of a life threatening medical emergency. This gives the PCP an opportunity to provide the member with the care he or she needs in the most appropriate manner.

The Physician's Role in Managed Care: The Specialist

The specialist is responsible for providing care as coordinated by the member's PCP. At each visit, it is necessary for the specialist's office to verify the member's coverage and to be aware of any referral requirements. If a member's coverage indicates that a referral is necessary and it is not in place, you must inform the member prior to services being rendered that he or she will be responsible for payment. Financial responsibility must be established at the time of each visit. Claims that are denied because there is not a valid referral in place, and no patient waiver exists, cannot be billed to the member.

It is the specialist's responsibility to keep the PCP informed about any care the patient may be receiving by promptly reporting the treatment plan or progress notes to the PCP.

OB-GYNs are also considered specialists and the routine OB-GYN services they provide do not require a referral. All female members have direct access to obstetrical/gynecological care, so they may receive care from their OB-GYN. To help coordinate care, the OB-GYN should routinely discuss the treatment plan with the patient's PCP. For OB-GYN services, the patient pays the PCP copay.

The Physician's Role in Managed Care for Members with Special Needs (Including Medicare Advantage Dual-eligibles)

For planned and unplanned transitions between care settings (a member’s usual care setting to a hospital, or from a hospital to the next setting), the sending provider is expected:

- To share the care plan with the receiving setting within one business day of notification of the transition.

- To inform the member (or the member's responsible party) of the care transition process.

- To inform the member (or the member's responsible party) about changes to the member's health status and plan of care.

- Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in
the Qualified Medicare Beneficiaries (QMB) program, a dual-eligible program which exempts individuals from Medicare cost-sharing liability. (See Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997).

- Balance billing prohibitions may likewise apply to other dual-eligible beneficiaries in Medicare Advantage (MA) plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost-sharing.

- Further, Medicare Advantage enrollees cannot be discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Discrimination based on “source of payment” means, for example, that MA providers cannot refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program.

Members who are eligible for both Medicare and Medicaid (dually eligible) may have certain services covered by the Medicaid programs. To find out which benefits are covered by the member’s Medicaid benefit, please call provider service at 1-877-327-1395.

Culturally and Linguistically Appropriate Services

Physicians are requested to provide culturally and linguistically appropriate services to BlueCross BlueShield members. Cultural competency in health care professionals results in healthier patients. Some of the most common misunderstandings between doctors and their patients are diagnosis, test results and prescription instructions. Understanding what you say to them about their health can mean the difference between your patients' compliance or non-compliance.

For information about free online training on Culture and Health Literacy with Continuing Education Units (CEUs), click on MENU > For Providers > Tools & Resources > Cultural & Language Resources > Cultural & Health Literacy Training on our provider website.

Provider Network Management and Operations and Provider Experience

Our Provider Network Management and Operations and Provider Experience teams are your primary link with BlueCross BlueShield. Our commitment to partnering with our participating providers is vital to providing quality coverage for our members. A Provider Network Management Specialist or Practice Account Manager will visit your office to share information and work with you to analyze practice patterns in an effort to help you provide quality, cost-effective care. With a variety of reports and educational material, we can customize information to meet your specific needs.
Our provider website, **bcbswny.com** includes a variety of convenient BlueCross BlueShield content such as:

- Provider and Facility Reference Manual
- Dental Reference Manual
- Chiropractic Reference Manual
- Quarterly newsletters (articles regarding product information, coding and billing guidelines, policy changes, etc.)
- Blue Bulletin news feed (our primary vehicle for communicating important updates and information to you once a month)
- Corporate medical protocols (guidelines providing clinically significant information about medical treatment and administrative policies)

Use your HEALTHeNET login for complete access to both non-secure and secure information in the Provider section of the BlueCross BlueShield website. To register for a HEALTHeNET login, go to [wnyhealthenet.org](http://wnyhealthenet.org).

For additional information on the services available to providers, please contact our Provider Network Management and Operations Department at 1-800-666-4627.

**Provider Service Centers**

Our Provider Service Center representatives are trained to assist you with any of the following, and much more:

- Answers to benefit questions
- To check on the status of a claim
- To request an adjustment

You can reach our Provider Service Centers from 8 a.m. to 5 p.m., Monday to Friday. To serve you best, BlueCross BlueShield has dedicated service centers for each line of business.

**Provider Telephone and Website Reference Guide**

<table>
<thead>
<tr>
<th>Provider Service</th>
<th>Traditional: 1-800-950-0051 or (716) 884-3461 Managed Care: 1-800-950-0052 or (716) 882-2616</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Enrollment</td>
<td>1-800-666-4627</td>
</tr>
<tr>
<td>Provider Network Management and Operations</td>
<td>1-800-666-4627</td>
</tr>
<tr>
<td>Provider Website</td>
<td><strong>bcbswny.com</strong></td>
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Section 2 – Credentialing/Recredentialing Program and Facility Application Protocol and Credentialing Process

Introduction

The Practitioner Credentialing and Recredentialing Programs address the selection and retention of practitioners for participation in BlueCross BlueShield of Western New York. The purpose of using credentialing and recredentialing criteria is to establish consistent, clear objectives for the credentialing and recredentialing of participating practitioners.

The practitioners to whom this program applies include physicians (MD, DO), oral surgeons (DDS, DMD), podiatrists (DPM), and other health care professionals acting within the scope of their licenses, practicing in the outpatient setting. Further, this program applies to the credentialing and recredentialing of individual practitioners, organized medical group practices, and practitioners participating in subcontracted networks.

The procedures established herein are to be implemented for BlueCross BlueShield where permitted by state laws and regulatory requirements and by existing contractual arrangements.

The decision to accept or retain a practitioner is based on the information available, including but not limited to the information gathered through a completed practitioner application, the re-evaluation process, and the verification of all collected information. This process takes place every 36 months.

BlueCross BlueShield does not discriminate against health care professionals who serve high-risk populations, or who specialize in the treatment of costly conditions, and/or provide certain services (i.e., abortions, HIV care). The provider credentialing and re-credentialing process is conducted in a non-discriminatory manner, without regard for: race, color, religion, sex, national origin, age, marital status, sexual orientation, and veteran status.

Periodic audits of denied credentialing files will be conducted to ensure that practitioners were not discriminated against. A spreadsheet will be maintained for audit purposes. In addition, BlueCross BlueShield will conduct periodic audits of practitioner complaints to determine if there are complaints alleging discrimination; ensure that a heterogeneous credentials committee is maintained, and obtain affirmative statements from those responsible for credentialing decisions that all decisions were made in a nondiscriminatory manner.

Medicaid Integrity/Disclosure of Ownership

The Medicaid Managed Care/Family Health Plus Plan Model Contract (18.9 (c)) indicates that the Contractor requires all network providers to monitor staff and
employees against the stated exclusion list (List of Excluded Individuals and Entities and the Restricted, Terminated or Excluded Individuals or Entities List) and report any exclusions to the Contractor on a monthly basis.

Also, in accordance with federal regulations (Section 42 CFR 455.106) and the Medicaid Managed Care/Family Health Plus Plan Model Contract (18.12 (b)), the managed care health plan/Contractor requires providers to disclose health care related criminal conviction information from all parties affiliated with the provider. Upon entering into an initial agreement or renewal of any agreement between the managed care health plan/contractor and its providers, the managed care health plan/contractor must disclose to the SDOH Division of Health Plan Contracting and Oversight in 20 working days of the disclosure date any conviction of a criminal offense related to that provider or provider’s managing employee involvement in any program under Medicare, Medicaid, or Title XX services program (Block grant programs).

As per federal regulation 42 CFR 455.104 and Medicaid Managed Care/Family Health Plus Plan Model Contract 18.6 (b), BlueCross BlueShield requires that participating providers disclose complete ownership, control and relationship information upon submitting application, executing the provider agreement, and within 35 days after any change in ownership. In accordance with federal regulation 42 CFR 455.105 and the Medicaid Managed Care/Family Health Plus Plan Model Contract 18.6 (c), and as cited in the Participating Provider Agreement within 35 days of the date of a request by the SDOH, OMIG or DHHS, the managed care organization/contractor will require from any subcontractor disclosure of ownership, with whom an individual network provider has had a business transaction totaling more than $25,000 during the 12-month period ending on the date of request.

A Disclosure of Ownership and Control form must be completed as part of the credentialing process to ensure compliance with the above referenced program requirements. Plan 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 the Medicare or Medicaid program.

The Disclosure of Ownership and Control form is located on our website under: Provider > Tools & Resources > Forms.

When credentialing and recredentialing criteria for participation, the practitioner:

- All sections of the CAQH application must be answered, completed and attested to within 180 days of credentialing decision date.
- Must hold a current valid license to practice in New York State and/or the state where the practitioner practices.
- Must have completed appropriate training for his/her profession.
- All physicians are required to be currently board certified in their area of specialty.
BlueCross BlueShield recognizes accreditation by the American Osteopathic Association (AOA), the American Board of Medical Specialties (ABMS), the American Board of Oral Surgeons for Oral and Maxillofacial Surgery for DDS and DMD practitioners, the Board of Podiatric Medicine, the American Board of Foot and Ankle Surgery for DPM, or the Royal College of Physicians and Surgeons of Canada (RCPSC) is required. RCPSC certification is not accepted in the following specialties: colorectal surgery, medical genetics, otolaryngology, thoracic surgery, and urology.

General practice is not a recognized specialty by BlueCross BlueShield.

Board certification exceptions may be granted to physician practitioners under the following conditions:

1. Have admitting privileges at one (1) or more in-network hospitals or written agreement with in-network provider/group that will admit on behalf of provider.
2. Completed an accredited residency program in their area of specialty.

Admitting privilege exceptions may be granted to physician practitioners under the following conditions. If any exceptions are granted, this must be documented in writing and included in the provider’s file:

1. If there is a demonstrated access issue, e.g., rural area, individual consideration may be given by the plan Medical Director or designee.
2. Practitioner possesses extraordinary credentials and potentially unique abilities worthy of consideration. Circumstances of this nature will be reviewed for consideration by the Medical Director or designee.
3. Physicians who are currently sitting for their Boards; a written letter from the practitioner will be submitted along with documentation from the Board stating the date when the provider will be sitting.

Primary Care Physician (PCP)
The physician must have completed postgraduate training in Family Practice, Internal Medicine, Geriatric primary care, Adolescent Medicine, or Pediatrics.

All primary care physicians must have a satisfactory on-site attestation and medical record review completed by the appropriate BlueCross BlueShield representative, as applicable.

Specialist Physician
The physician must have successfully completed postgraduate training in the specialty the practitioner wishes to practice as a specialist. Providers are required to have unrestricted privileges in the specialty requested at every hospital in which the physician practices, with the exception of Radiology, Dermatology, Pathology, and Anesthesia (at Ambulatory Surgery Centers).
Dual Appointment Physicians
A physician who seeks to be credentialed both as a primary care physician and a specialist physician must demonstrate:

- The training requirements for both primary care physician and specialty physician have been successfully completed.
- All dual appointment physicians must have a satisfactory on-site review.
- All dual appointment physicians must have a satisfactory medical record review.

Credentialing Overview

The purpose of the selection process is to include only those practitioners who meet the established credentialing criteria.

All applications are reviewed by the Chief Medical Officer or designee. The credentials, when complete, are presented to the Credentials Committee that is under the direction of the BlueCross BlueShield Medical Director. The committee meets at a minimum of four times per year, and is attended by other appropriate personnel to include but not limited to representatives from Quality Management, Special Investigations Unit, and Provider Network, along with physicians from the community.

The Chief Medical Officer or Medical Director\Designee and Credentialing Committee make the final determination for participation. Credentialing criteria are developed for each type of health care professional who participates with BlueCross BlueShield's Managed Care product(s). These criteria are developed and approved by the Credentials Committee. Criteria include specific requirements relative to each specialty.

The goal of the credentialing process is to ensure that the members of BlueCross BlueShield will be cared for by qualified practitioners in appropriate settings. The on-site attestation review and medical record review for primary care physicians, obstetricians and gynecologists (OB-GYN), and high-volume behavioral health specialists will be used along with other information compiled in the credentialing process as a tool for improvement of the quality of care and service. An important feature of the credentialing process will be to identify areas that have the potential for improvement and to work with the practitioners to identify ways in which the improvement can be achieved.

Universal Credentialing Electronic Application
BlueCross BlueShield now requires providers to enter their credentialing/recredentialing information (free of charge) into a single, uniform online application. This application meets the credentialing needs of health plans, hospitals, and other health care organizations. The CAQH ProView provider data-collection service streamlines the initial application and re-credentialing processes, reduces provider administrative burdens and costs, and offers health plans and networks real-time access to reliable provider information for claims processing, quality assurance and member services, such as directories and referrals.
Providers submit data through CAQH ProView to a secure, state-of-the-art data center. Providers then authorize health plans and other organizations to access the information. Periodic provider updates help ensure that the information is always current.

CAQH ProView is supported by the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, the Medical Group Management Association, the National Association of Medical Staff Services and other provider organizations, and recognized by a number of state legislators and insurance commissioners. The newest version of the CAQH ProView application meets all related URAC, National Committee for Quality Assurance and the Joint Commission standards.

Providers are required to enter their credentialing data with CAQH ProView through the CAQH ProView website: upd.caqh.org. Once this application is complete, providers must allow BlueCross BlueShield to view this information by choosing this option at the completion of the application. For more information, or if there are additional questions, you may contact the Provider Enrollment Department at 1-800-666-4627.

Credentialing Process

A. Application for Practitioner Participation
Instructions for enrolling as a participating provider can be found on our website at bcbswny.com.

Initial Credentialing
Providers can enroll into our health plan by filling out the Universal Credentialing Application with CAQH ProView, the Council for Affordable Quality Healthcare.

How it Works

To access the Universal Provider Datasource®, go to upd.caqh.org:

- Log on with your username and password.
- Enter your CAQH Provider ID (if unknown, call CAQH at 1-888-599-1771).
- Enter or update your information.
- Authorize BlueCross BlueShield of Western New York access to your information electronically.
- If you do not have a CAQH application, refer to the 'First Time Here' information and click 'Register Now'.
- Complete this form and return it to the fax number on the form.

Once you have completed the CAQH application, please complete the Provider Enrollment Form (PEF) and Disclosure of Ownership and Control form and return both to 716-887-2056.

A Participating Provider Agreement, Disclosure of Ownership and Control form, and instructions will be sent by the Provider Enrollment Department to the practitioner if the panel the practitioner is seeking participation in is open. Should a prospective
practitioner request an application for a specialty in which the panel is closed, the practitioner may submit a letter of interest. These letters are kept on file until such time that the panel is reopened to that specialty. All appropriate practitioners operating in the service area are contacted when the panel is reopened in a requested specialty.

The application will be processed if complete information is provided on the CAQH application. If the information supplied on the application is incomplete, the application processor is responsible for contacting the applicant, initially by phone and/or email, to obtain details and documentation, as appropriate. Information will be deemed incomplete if information or documentation requested on the application is not provided, if responses provided require further explanation, if details related to affirmative answers to disclosure questions are not provided, or if any documents have expired prior to making a decision to accept or not to accept an applicant.

Upon receipt of a signed provider agreement, Disclosure of Ownership and Control, and complete CAQH application:

1. The Provider Enrollment Specialist reviews the application for completeness.
2. The applicant is notified if any additional information is needed.
3. Primary source verification of specified credentialing criteria documentation will be initiated by the credentialing specialist.
4. The credentialing specialist will also verify if the provider has elected to opt-out of Medicare, as well as verify that the provider is not excluded from participation with Medicaid Managed Care or Medicare.
5. The completion of an application does not guarantee acceptance into the BlueCross BlueShield panel. The prospective practitioner will not be reimbursed as an in-network provider until they have been notified by BlueCross BlueShield of their approval. The practitioner will be notified, in writing, of our decision.
6. BlueCross BlueShield does not back-date any effective date for legal reasons.

Upon receipt of all relevant documents, the credentials are reviewed by the Chief Medical Officer or designee. The Chief Medical Officer or designee will make the final determination regarding participation for level 1 practitioners. All level 2 or level 3 practitioners will be individually presented to the Credentialing Committee. The practitioner is notified in writing of the final decision.

Upon acceptance into BlueCross BlueShield the applicant will be provided with materials and appropriate office staff training:

- Primary Care Physicians - Practice Account Managers
- Specialist - Provider Network Management and Operations Specialist
- Behavioral Health - Regional Provider Contract Manager
B. Office Site Review
A review of primary care physicians, obstetricians/gynecologists, ophthalmologists, and behavioral health specialist office sites must be completed as a requirement of participation. The physician office site review or office compliance attestation addresses, at a minimum, access to services, waiting area amenities, safety and adequacy of equipment and the treatment area. The physician office site review form and office compliance attestations are used for this purpose. The office compliance attestation will require the office to attest to the requirements by signing the form and returning by email or fax within five (5) business days. The office site review will require a physical visit to the site.

C. Medical Record Review
The medical record components, as described below, must be included within each patient record as a requirement of participation for specific medical specialties. These medical specialties include, without limitation, the primary care specialties (internal medicine, family practice, pediatrics, geriatrics, adolescent medicine, and general practice) obstetrics-gynecology, and high-volume behavioral health specialists.

An office site review or office compliance attestation is completed to verify that the physical components of the medical record (structure, legibility, and completeness) are acceptable and meet BlueCross BlueShield quality standards.

The participating physician/provider shall prepare and maintain in accordance with program requirements all appropriate medical and billing records on covered persons receiving covered services. Medical records of covered persons will include, but not be limited to: reports from specialist physicians, medication orders, discharge summaries, records of emergency care received by the covered person, and such other information as the health plan requires.

Participating physician/provider shall maintain covered persons’ medical records and personal identifiable health information as confidential so as to comply with applicable state and federal laws regarding the confidentiality of medical records, including, without limitation, the Health Insurance Portability and Accountability Act of 1996, as amended. The records shall be maintained in accordance with prudent record-keeping procedures and as required by practice standards and law, but in no event shall any medical records be retained for less than six years for adult covered persons and, with respect to minor covered persons, six years from the date of majority, as applicable, following termination or for such longer period as may be required by law.

D. Timetable
A new provider application may be processed within 60 days. Clean applications are processed more quickly.

An application is considered clean if:

- The CAQH/application is filled out accurately and has been attested to within 180 days of filing the application.
• All related credentialing documents are attached and current.
• The application is in compliance with all the BlueCross BlueShield of Western New York credentialing policies and procedures.
• Primary source verification is successfully completed by BlueCross BlueShield credentialing specialists.
• The credentialing Medical Director has signified approval of the application.
• Provider information has been successfully updated in the claims processing system.

New provider applications that do not meet our established credentialing criteria will have the deficiencies noted and will require further intervention by the Credentialing Specialist. These applications will require additional time to process, however, they will be completed as quickly as possible.

The credentialing process will be completed within 60 days from the receipt of a completed application. A notice is sent to the provider that informs them as to whether they are credentialed, whether additional time is needed, or that their application is denied.

After review and approval by the Credentials Committee, the Credentialing Specialist forwards the provider’s approved credentialing file to the appropriate Provider File Enrollment staff for entry into the provider system. This entry generates a welcome letter, which contains the effective date of participation, the provider number, and a copy of the executed contract.

**Recredentialing Overview**

A. Collection of Information
The objective of the Recredentialing Program is to ensure the retention of practitioners who have the same qualifications that are required for initial participation under the Practitioner Credentialing Program. The information provided will be evaluated in accordance with the practitioner credentialing criteria.

The decision to retain or not retain a participating practitioner is based on the totality of information available, including, but not limited to the information gathered through the re-credentialing process and verified as complete by the Credentialing Committee. The information gathered is treated in a confidential manner and the disclosure of such information will be limited to those parties who have an appropriate reason to have access to the information. Review of information to evaluate continued participation of practitioners is ongoing and periodic.

All recredentialing information is reviewed by the Chief Medical Officer or designee. The recredentialing materials, when complete, are presented to the Credentialing Committee. The Credentialing Committee makes the final decision regarding continued participation. Recredentialing criteria are developed for each type of health care professional who participates with BlueCross BlueShield. These criteria are developed
and adopted by the Credentialing Committee. Criteria include specific requirements relative to each specialty.

B. Recredentialing Process
As a participating provider, you will be re-credentialed at a minimum of every 36 months.

Your CAQH application must be updated for the re-credentialing process to be completed.

A critical component of recredentialing includes the evaluation of the applicable information obtained through the following sources as applicable:

1. Quality reviews
2. Office site reviews, as applicable
3. Medical records reviews, as applicable
4. Utilization data
5. Member satisfaction surveys
6. Member complaints
7. Adherence to the policies and procedures of BlueCross BlueShield
8. Verification of renewal of credentials with expiration dates.

Credentials that expire include:
- State license/registration to include sanction status
- DEA certificate
- Malpractice coverage
- Board certification, where applicable
- Medicare/Medicaid sanction status
- Medicare Opt-Out status
- Medicare Preclusion List

Proof of renewal of these documents is required upon recredentialing from primary sources for participating practitioners. Copies of documents may be requested from participating practitioners through email. Documents may also be obtained directly from the CAQH application.

C. Recredentialing on CAQH
- Practitioners will be required to complete the re-credentialing process, at a minimum, on a triennial basis (at least every 36 months). Providers must regularly update their CAQH application for the re-credentialing process to be completed timely.
- All physicians are required to be currently board certified in their area of specialty.
- As in the application for practitioner participation, the information requested pertains to, but is not limited to, hospital privileges, professional disciplinary actions, license suspension or revocation (whether or not stayed), malpractice history, the physical/mental health of the practitioner, and chemical dependency/substance abuse history. As in the Credentialing Program, any practitioner who answers affirmatively to any of the disclosure questions, and who does not provide adequate
information regarding the matter, must be contacted to obtain details and documentation.

- Recredentialing of any practitioner who answers affirmatively to any disclosure question is subject to review by the Credentialing Committee.
- Providers that are sanctioned by the NYS Medicaid Program will be removed from participation in the BlueCross BlueShield Medicaid/CHP/FHP panels. Providers that are sanctioned by the Medicare Program will be removed from participation in all government program panels.

The CAQH application must be signed and dated by the practitioner to be considered complete.

D. Ongoing Re-evaluation
Each practitioner's performance as a participating practitioner will be monitored on an individual basis. Each physician must comply with the requirements under contractual obligations with BlueCross BlueShield. Data will be maintained in the Internal Performance Evaluation Directory and incorporated as it becomes available. This information will be reviewed by the Credentialing Committee for the purpose of practitioner recredentialing.

1. Clinical Measures - sources of information may include, but are not limited to, Utilization Management reports, medical record reviews and focused quality of care reviews.
2. Service Measures - sources of information may include, but are not limited to, information from grievances filed, member complaints, feedback regarding PCP changes and member satisfaction surveys.

E. Administration of Ongoing Review
A practitioner's profile will accumulate continuously as data becomes available. The data will be incorporated in each participating practitioner's credentialing file. In addition, it may be captured in a report card that summarizes number and type of occurrence (e.g., grievances and complaints, results of medical record reviews and quality of care reviews).

F. Timetable
Applicable physicians and health care professionals will be reviewed, at a minimum, on a 36 month re-credentialing cycle. BlueCross BlueShield may require participating practitioners to be re-credentialled more frequently at the recommendation of the Medical Director, Credentialing Committee or the Quality Improvement Committee or any other internal source.

**Credentialing Process - Non-MD Providers**

A. Application for Practitioner Participation
Instructions for enrolling as a participating provider can be found on our website at bcbswny.com.
Initial Credentialing
Providers can enroll into our health plan by filling out the Universal Credentialing Application with CAQH, the Council for Affordable Quality Healthcare.

How it Works
To access the Universal Provider Datasource®, go to upd.caqh.org:
• Log on with your username and password.
• Enter your CAQH Provider ID (if unknown, call CAQH at 1-888-599-1771).
• Enter or update your information.
• Authorize BlueCross BlueShield of Western New York access to your information electronically.
• If you do not have a CAQH application, refer to the 'First Time Here' information and click ‘Register Now’.
• Complete this form and return it to the fax number on the form.

After you have completed the CAQH application, please complete the Provider Enrollment Form (PEF) and Disclosure of Ownership and Control form and return both to 716-887-2056.

A Participating Provider Agreement, Disclosure of Ownership and Control form, and instructions will be sent by the Provider Enrollment Department to the practitioner if the panel the practitioner is seeking participation in is open. Should a prospective practitioner request an application for a specialty in which the panel is closed, the practitioner may submit a letter of interest. These letters are kept on file until such time that the panel is reopened to that specialty. All appropriate practitioners operating in the service area are contacted when the panel is reopened in a requested specialty.

The application will be processed if complete information is provided on the CAQH application. If the information supplied on the application is incomplete, the application processor is responsible for contacting the applicant, initially by phone, to obtain details and documentation, as appropriate. Information will be deemed incomplete if information or documentation requested on the application is not provided, if responses provided require further explanation, if details related to affirmative answers to disclosure questions are not provided, or if any documents have expired prior to making a decision to accept or not to accept an applicant.

Upon receipt of a signed provider agreement and complete CAQH application:

• The Provider Enrollment specialist reviews the application for completeness.
• The applicant is notified if any additional information is needed.
• Primary source verification of specified credentialing criteria documentation will be initiated by the credentialing specialist.
• The credentialing specialist will also verify if the provider has elected to opt-out of Medicare, as well as verify that the provider is not excluded from participation with Medicaid Managed Care or Medicare. Providers that are sanctioned by the New York State Medicaid Program will be excluded from participation in the BlueCross BlueShield Medicaid/CHP/FHP panels. Providers that are sanctioned by the
Medicare program will be excluded from participation in all government program panels.

- The completion of an application does not guarantee acceptance into the BlueCross BlueShield panel. The prospective practitioner will not be reimbursed as an in-network provider until they have been notified by BlueCross BlueShield of your approval. The practitioner will be notified, in writing of our decision. BlueCross BlueShield does not back-date any effective date for legal reasons.
- BlueCross BlueShield reserves the right to deny participation to any practitioner that is an employee or an independent practitioner of a direct competitor.

If there is a substantial difference between the information provided by the practitioner and primary source verification, the practitioner will be notified and required to provide documentation prior to their credentials being presented to the Credentialing Committee.

Upon receipt of all relevant documents, the credentials are reviewed by the Chief Medical Officer or designee. The Chief Medical Officer or designee will make the final determination regarding participation for level 1 practitioners. All level 2 or level 3 practitioners will be individually presented to the Credentialing Committee. The practitioner is notified, in writing of the final decision.

The applicant will be provided with materials and appropriate office staff training by the Provider Relations and Contracting account specialist upon acceptance into BlueCross BlueShield.

**B. Timetable**

A new provider application may be processed within 60 days. Clean applications are processed more quickly.

An application is considered clean if:

- The CAQH/application is filled out accurately and has been attested to within 180 days of filing the application.
- All related credentialing documents are attached and current.
- The application is in compliance with all the BlueCross BlueShield of Western New York credentialing policies and procedures.
- Primary source verification is successfully completed by BlueCross BlueShield credentialing specialists.
- The Chief Medical Officer or designee has signified approval of the application.
- Provider information has been successfully updated in the claims processing system.

New provider applications that do not meet our established credentialing criteria will have the deficiencies noted and will require further intervention by the Credentialing Specialist staff. These applications will require additional time to process, however, they will be completed as quickly as possible.

The credentialing process will be completed within 60 days from the receipt of a completed application. A notice is sent to the provider that informs them as to whether
they are credentialed, whether additional time is needed, or that their application is denied.

After review and approval by the Credentialing Committee, the Credentialing Specialist forwards the provider’s approved credentialing file to the appropriate Provider File staff for entry into the provider system. This entry generates a welcome letter which contains: the effective date of participation, the provider number, and a copy of the executed contract.

**Credentialing Process – Facility/Durable Medical Equipment Providers**

Application for Facility/DME Participation
The facilities that these instructions apply to include the following: skilled nursing facilities (SNF); home care agencies; hospitals; free standing surgical centers; facilities providing mental health and substance abuse services, including, but not limited to facilities providing inpatient, residential, and ambulatory services; hospice; clinical labs; comprehensive outpatient rehab facilities (CORF); end stage renal disease facilities; portable X-ray; federally-qualified health centers (FQHC); personal care; durable medical equipment (DME); ambulance; urgent care; independent diagnostic testing facilities (IDTF); and facilities seeking participation/re-participation with BlueCross BlueShield of Western New York.

Medicaid Integrity/Disclosure of Ownership
The Medicaid Managed Care/Family Health Plus Plan Model Contract (18.9 (c)) indicates that the contractor requires all network providers to monitor staff and employees against the stated exclusion list (List of Excluded Individuals and Entities and the Restricted, Terminated or Excluded Individuals or Entities List) and report any exclusions to the managed care plan/contractor on a monthly basis.

Also, in accordance with federal regulations (Section 42 CFR 455.106) and the Medicaid Managed Care/Family Health Plus Plan Model Contract (18.12 (b)), the managed care health plan/contractor requires providers to disclose health care related criminal conviction information from all parties affiliated with the provider. Upon entering into an initial agreement or renewal of any agreement between the managed care health plan/contractor and its providers, the managed care health plan/Contractor must disclose to the SDOH Division of Health Plan Contracting and Oversight in 20 working days of the disclosure date any conviction of a criminal offense related to that provider or provider’s managing employee involvement in any program under Medicare, Medicaid, or Title XX services program (Block grant programs).

As per federal regulation 42 CFR 455.104 and Medicaid Managed Care/Family Health Plus Plan Model Contract 18.6 (b), BlueCross BlueShield requires that participating providers disclose complete ownership, control and relationship information upon submitting application, executing the provider agreement, and within 35 days after any change in ownership. In accordance with federal regulation 42 CFR 455.105 and the Medicaid Managed Care/Family Health Plus Plan Model Contract 18.6 (c), and as cited
in the Participating Provider Agreement within 35 days of the date of a request by the SDOH, OMIG or DHHS, the managed care organization/contractor will require from any subcontractor disclosure of ownership, with whom an individual network provider has had a business transaction totaling more than $25,000 during the 12-month period ending on the date of request.

A Disclosure of Ownership and Control form must be completed as part of the credentialing process to ensure compliance with the above referenced program requirements. 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 the Medicare or Medicaid program.

A Participating Facility Agreement, Disclosure of Ownership and Control form, enrollment application, and instructions will be sent by the Facility Contracting Department to the facility if the panel the facility is seeking participation in is open. Should a prospective facility request an application for a specialty in which the panel is closed, the facility may submit a letter of interest. These letters are kept on file until such time that the panel is reopened to that specialty. All appropriate facilities operating in the service area are contacted when the panel is reopened in a requested specialty.

The application will be processed when complete information is provided for the enrollment application. If the information supplied on the application is incomplete, the application processor is responsible for contacting the applicant, initially by phone, to obtain details and documentation, as appropriate. Information will be deemed incomplete if the information or documentation requested on the application is not provided, if responses provided require further explanation, if details related to affirmative answers to disclosure questions are not provided, or if any documents have expired prior to making a decision to accept or not to accept an applicant.

The following CMS-approved accreditation organizations will be acceptable accreditations for facilities:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Program Type</th>
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</thead>
<tbody>
<tr>
<td>Accreditation Association for Ambulatory Health Care (AAAHC)</td>
<td>Ambulatory Surgical Center (ASC)</td>
</tr>
<tr>
<td></td>
<td>DME</td>
</tr>
<tr>
<td>Accreditation Commission for Health Care, Inc.</td>
<td>Home Health Agencies (HHA)</td>
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<tr>
<td></td>
<td>Hospice</td>
</tr>
<tr>
<td>American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)</td>
<td>Ambulatory Surgical Center (ASC)</td>
</tr>
<tr>
<td></td>
<td>Rural Health Clinics (RHC)</td>
</tr>
<tr>
<td>American Osteopathic Association/Healthcare Facilities Accreditation Program</td>
<td>Ambulatory Surgical Center (ASC)</td>
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<tr>
<td></td>
<td>Hospitals</td>
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<tr>
<td>Community Health Accreditation Program</td>
<td>Home Health Agencies</td>
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<td></td>
<td>Hospice</td>
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<td></td>
<td>DME</td>
</tr>
<tr>
<td>DNV Healthcare (DNV)</td>
<td>Hospitals</td>
</tr>
<tr>
<td>The Joint Commission (JC)</td>
<td>Ambulatory Surgical Centers</td>
</tr>
</tbody>
</table>
## Upon receipt of submitted application:

1. The credentialing specialist reviews the application for completeness.
2. The applicant is notified if any additional information is needed.
3. Primary source verification of specified credentialing criteria documentation will be initiated by the credentialing specialist to include:

   a. All sections of the application and Disclosure of Ownership and Control form answered/completed.
   b. A copy of their current Accreditation certificate or a copy of their Medicare certification letter. If the actual certificate is not included in the application, the appropriate websites will be queried. The provider must maintain current Accreditation or Medicare certification.
   c. If not accredited, a copy of the last Department of Health review to include deficiencies and their plan of correction, if applicable. If not included, the DOH website will be queried.
   d. Operating license:
      - A copy of the New York State operating license or verification via Internet or Health Facility Directory published by the New York State Education Department.
      - For behavioral health entities, a copy of the Office of Mental Health (OMH) or Office of Alcohol & Substance Abuse Services (OASAS) operating license or verification via internet published by OMH or OASAS.
      - 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 if applicable.
   e. A sample of the grievance Policy/Procedure (credentialing only) – if not accredited
   f. A sample of grievance logs and actions taken (credentialing only) – if not accredited
   g. A copy of the Quality Improvement Program (credentialing only) – if not accredited

4. The Credentialing Specialist will also verify if the facility has elected to opt-out of Medicare, as well as verify that the provider is not excluded from participation with Medicaid Managed Care or Medicare.
5. The completion of an application does not guarantee acceptance into the BlueCross BlueShield panel. The prospective facility may not make any appointments or see any patients until they have been notified by BlueCross BlueShield that they have been approved for participation. BlueCross BlueShield does not back-date any effective date for legal reasons.

6. BlueCross BlueShield reserves the right to deny participation to any facility that is an employee or an independent practitioner of a direct competitor.

7. Each facility’s performance, as a participating facility, will be monitored on an individual basis. Each facility must comply with the contractual obligations with BlueCross BlueShield, including having a valid unsanctioned license, whether or not stayed, to practice medicine in the State of New York.

8. All facilities will be required to be Accredited or Medicare Certified, as evidenced by their Medicare Provider number. Exceptions apply for specific DME suppliers who do not participate with Medicare and providers who participated with NYS Medicaid programs only (for example: Personal Care Agencies)

9. The credentialing staff presents the credentialing file to the Chief Medical Officer or designee for review.

10. The Chief Medical Officer or designee reviews the file, makes the final determination of participation/re-participation and documents the decision on the Credentialing Process Form and will verify review by signing in the space provided.

11. A list of all facilities that meet the minimum requirements of BlueCross BlueShield is presented to the Credentials Committee. The time frame to verify credentials and receive sign-off from the credentials committee will take no longer than 180 days as defined by CMS.

12. If the facility is accepted, the credentialing staff forwards the credentialing file to the appropriate Provider Enrollment staff for entry into the provider data system.

13. The facility will be notified, via e-mail, within sixty (60) calendar days of being credentialed, of their participation status.

Recredentialing
At a minimum, every three years, the credentialing staff will obtain information on the following for each facility as applicable:

Using an internal report that lists participating facilities and contains their operating certificate, provider number, and Medicare number, the Credentialing Department will research via the New York State website or the Health Facility Directory to ensure that the facility is accredited, Medicare certified, or has had a recent DOH review and sanctions.

Rights of the Practitioner: To Review Credentialing/Recredentialing Information
BlueCross BlueShield is committed to maintaining accurate information and ensuring that providers are informed in the event that credentialing information obtained from other sources varies substantially from the information obtained from the practitioner.
The practitioner has the right to: review the information submitted in support of their credentialing application; correct erroneous information; receive the status of their credentialing / recredentialing application, upon request. If there is information substantially different from information submitted by the practitioner, the practitioner will be notified by certified letter of the discrepancy and asked to respond within 15 business days. If no correction is received in the allotted time, information received from the primary source will be considered to be correct and any decisions will be based on the primary source information.

**Restricted Procedures: Credentialing**

In the interest of providing quality care for our members, BlueCross BlueShield requires additional training for certain procedures. To measure the additional training, we require that a physician be board certified to perform the following or provide documentation of appropriate training:

<table>
<thead>
<tr>
<th>Restriction Procedures</th>
<th>Accepted Board</th>
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</thead>
<tbody>
<tr>
<td>Allergy Testing and Therapy Codes</td>
<td>American Board of Allergy and Immunology* &lt;br&gt;*Conjoint Board of the American Board of Internal Medicine or American Board of Pediatrics</td>
</tr>
<tr>
<td>Holter Monitor EKG Stress Tests</td>
<td>American Board of Internal Medicine with a subspecialty in Cardiovascular Disease.</td>
</tr>
<tr>
<td>Echocardiograms</td>
<td>American Board of Pediatrics with a subspecialty in Pediatric Cardiology</td>
</tr>
<tr>
<td>Esophagoscopy</td>
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</tr>
<tr>
<td>Upper GI/Endoscopy</td>
<td>American Board of Gastroenterology</td>
</tr>
<tr>
<td>Small Bowel &amp; Stoma Endoscopy</td>
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<tr>
<td>Sigmoidoscopy (Flexible, Fiberoptic)</td>
<td></td>
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<tr>
<td>Colonoscopy - Beyond Splenic Flexure</td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td>American Board of Radiology</td>
</tr>
<tr>
<td>Fetal Non-Stress</td>
<td>American Board of Obstetrics and Gynecology</td>
</tr>
</tbody>
</table>

- The Corporate Credentialing area will also research the physician's:
  - current credentials
  - area of study/programs attended during residency, fellowship, and continuing education
  - delineation of primary admitting hospital privileges
  - requirements/criteria used by hospital to privilege the requested procedure/service
  - references
  - This information is presented to the BlueCross BlueShield Medical Director
Special Consideration Criteria and Termination Criteria
These guidelines are based on the New York State Public Health Law Article 44, New York State Department of Health Chapter 98, Health Care Quality Improvement Act and National Committee of Quality Assurance Standards. They were reviewed by our Physician Credential Committee and accepted.

A practitioner (physician or non-physician) MAY NOT be terminated solely for the following reasons:
1. If the practitioner advocated on behalf of an enrollee;
2. Filed a complaint against BlueCross BlueShield;
3. Appealed a decision of BlueCross BlueShield;
4. Provided information or filed a report pursuant to PHL - 4406-C regarding prohibitions of the Plan(s);
5. Requested a hearing or review.

On-Going Course of Treatment
BlueCross BlueShield will permit an enrollee to continue an ongoing course of treatment for a transitional period (up to 90 days) as long as the practitioner being terminated is not causing imminent harm to the member and the practitioner agrees to the following:
1. To meet the BlueCross BlueShield Quality Assurance Standards;
2. To accept as payment in full the payment rates that were in effect when the practitioner participated with BlueCross BlueShield;
3. Agrees to provide BlueCross BlueShield with all necessary information related to the member's care and;
4. Agrees to adhere to all relevant policies and procedures established by BlueCross BlueShield including, but not limited to, rules regarding preauthorization of services and referrals;
5. Assist in the transition of the member's medical records;
6. Freely communicating with patients regarding any aspect of their care. This shall include but not be limited to, discussions involving testing, diagnosis, treatment, risks, and outcome choices as well as costs and insurance coverage or reimbursement available under the patient's current health insurance contract.
A. Corrective Action
Responsibility for decisions in regard to special consideration rests with the Medical Director or designee.

The Chief Medical Officer or designee may take the following actions with individual practitioners or providers to ensure quality of care and service to members and/or subscribers through integrated review and evaluation mechanisms that are efficient and effective in resolving instances of substandard care or patient care outside the accepted professional practice:

1. Direct consultation and education with the practitioner under review
2. Probationary status
3. Hold all payment of claims
4. Conduct focused review of ambulatory or hospital care
5. Suspend or terminate the practitioners' agreement (see Termination/Suspension)

The Chief Medical Officer or designee will notify the practitioner of his decision and the basis thereof, in writing. If remedial action is taken, the Medical Director or designee will encourage improved quality of care and competence through education. BlueCross BlueShield will work closely with the practitioner to educate and assist them in achieving compliance with BlueCross BlueShield standards. Based on the decision of the Medical Director or designee, BlueCross BlueShield will re-evaluate the practitioner's performance at predetermined times in regard to the identified concerns.

B. Termination without Recourse to a Hearing
BlueCross BlueShield may terminate a practitioner without providing the practitioner recourse to a hearing for any of the following reasons:

1. Imminent harm: BlueCross BlueShield, in its sole judgement and based upon its review of relevant information, determines that the practitioner poses an imminent harm to patient care
2. Fraud: BlueCross BlueShield determines that the practitioner has engaged in fraud; the determination of fraud may be the result of a determination made by BlueCross BlueShield, in its sole judgement, with respect to internal cases of fraud or a determination made by a governmental, law enforcement or other appropriate outside agency with respect to external cases of fraud
3. Disciplinary action: a final disciplinary action has been taken by a state licensing board or other governmental agency that impairs the practitioner's ability to practice
4. Death or retirement: the practitioner is deceased or has retired from active participation in a medical practice

C. Termination
In accordance with Public Health Laws 4406-d, BlueCross BlueShield offers specific rights to a provider if it becomes necessary to terminate his or her provider agreement. In no event shall determination be effective earlier than 60 days from receipt of the notice of termination or otherwise provided by law.
Responsibility for decisions in regard to termination rests with the Medical Director or designee. When circumstances are of such a nature that prompt and immediate action is necessary to maintain the minimum quality standards of BlueCross BlueShield and/or if the practitioner poses an imminent danger to BlueCross BlueShield members, the Medical Director or designee has the authority to terminate the practitioner agreement immediately, subject to appeal.

The Chief Medical Officer or designee will initiate action under the following circumstances:

1. Engages in conduct of an illegal, immoral or inappropriate nature, which BlueCross BlueShield, in its sole judgement, determines capable of negatively impacting BlueCross BlueShield and/or its practitioner network(s)
2. Loses malpractice insurance coverage or fails to maintain malpractice insurance coverage in the minimum amounts required by BlueCross BlueShield
3. Loses Drug Enforcement Agency certification
4. Loses hospital privileges (if the practitioner only has privileges at one hospital), unless the practitioner arranges to have another practitioner perform admissions on the practitioner’s behalf. (See “On-Call Relationships” provided in the BlueCross BlueShield application, Mid-level CRNA Practitioner; “On-Call Relationships” provided in the BlueCross BlueShield application, Allied Health Practitioner; and “On-Call Relationships and “Appropriate Coverage Arrangements for PCPs” provided in the BlueCross BlueShield application, Physician)
5. Falsifies and/or materially omits or misstates information on the practitioner’s credentialing or recredentialing application and/or profile
6. Fails to comply with credentialing and/or recredentialing policy, e.g., fails to return applicable documentation, including the application, reapplication, or copies of requested verification and/or fails to respond to requests for additional information
7. Fails to comply with BlueCross BlueShield Utilization Management and/or Quality Management Policies and Protocols as are communicated to the practitioner from time to time
8. Fails to meet probationary requirements (see BlueCross BlueShield Credentialing Program; Probationary Status Policy and Procedure, as amended, which specifies the range of actions that may be taken to improve practitioner performance prior to termination)
9. Fails to cooperate with BlueCross BlueShield in obtaining copies of medical records and/or in performance of BlueCross BlueShield audit functions
10. Violates any provision(s) of the Practitioner Agreement, or BlueCross BlueShield otherwise has the right to terminate the practitioner under the terms of the Practitioner Agreement or applicable law

In addition, BlueCross BlueShield may terminate a practitioner (with recourse to a hearing) for any other competency or professional conduct reason, which BlueCross BlueShield, in its sole judgement, determines to be appropriate under the circumstances.
D. Appeal
Once a practitioner is identified for termination, a letter is delivered by certified mail to the practitioner.

The notice of termination will include information advising of the following rights:
- An explanation of the reason for the termination will be provided.
- The practitioner may request a hearing or review, at the provider’s discretion, before a panel of at least three people appointed by BlueCross BlueShield. At least one-third of the panel will consist of clinical peer in the same or similar specialty.
- The request for the hearing must be made within 35 days from the date the notice was provided.
- The hearing will be held within 30 days of BlueCross BlueShield's receipt of a request for a hearing.
- The practitioner will receive the written decision of the panel within 20 calendar days of its decision. The panel will determine whether the practitioner should be reinstated with or without conditions or whether his/her participating agreement should be terminated.
- If the practitioner is terminated, they are not eligible to reapply for participation unless BlueCross BlueShield determines there has been a substantial change in information and it has been at least 12 months since the termination.

A hearing is not available if a practitioner is being terminated for one of the following reasons:
1. There has been a final disciplinary action by a state licensing board or other governmental agency that impairs the provider’s ability to practice.
2. A determination of fraud on the part of the practitioner.
3. The corporation obtains information that, in the corporation’s sole judgment, indicates the practitioner may cause or is causing imminent harm to BlueCross BlueShield members.

E. Non-Renewal
The practitioner or BlueCross BlueShield may exercise a right of non-renewal of his or her participating agreement either at the end of the period noted in the contract, or with 60 days’ notice, each January first, occurring after the contract has been in effect at least one year. The practitioner will qualify for appeal rights if non-renewed.

F. Re-Application
Any practitioner, physician and non-physician, who is terminated by BlueCross BlueShield either voluntarily or involuntarily, may only re-apply to participate in BlueCross BlueShield’s network(s) if:

(a) There has been a substantial change in the information that led to the termination; and
(b) At least two (2) years have passed since the effective date of termination or non-renewal
Primary Care Physician Responsibilities

A primary care physician's role is that of a medical manager, providing and coordinating medical care for BlueCross BlueShield members. A primary care physician is responsible for determining the health care needs of his/her patients, for directly providing many of these needs and for coordinating the services of other providers. Primary care specialties include family practice, general practice, internal medicine, geriatrics, adolescent medicine, and pediatrics. BlueCross BlueShield primary care physicians agree to:

- Support and comply with the terms of BlueCross BlueShield.
- Provide care that is medically appropriate and proficiently delivered to produce optimal patient outcomes and satisfaction.
- Coordinate the member's access to high quality, cost-effective health care delivery; make all reasonable efforts to provide diagnostic and treatment care within his/her expertise; and refer the patient to participating network providers as defined in the provider directory.
- Collect specified copayments from members for office visits.
- Ensure the protection of confidentiality of members' medical records.
- Cooperate with all BlueCross BlueShield medical and quality management policies and procedures; demonstrate a willingness to examine his/her practice patterns as they pertain to feedback from the health plan and remains open to the possibility of modifying his/her clinical behavior to conform with the professional norms.
- Be available 24 hours a day, seven days a week or arrange coverage with a participating physician to provide patient access during his/her absence.
- Maintain an office that is clean, accessible, safe, supportive of patient's needs and supportive of the health plan's policies and procedures. If office and/or facilities are not wheelchair accessible, the practitioner must provide a documented plan of how wheelchair dependent patients are accommodated.
- Agree to comply with the terms of the health plan's preauthorization and credentialing requirements as well as other contract terms, policies and procedures.
- Maintain current credentialing standards.
- Participate in member satisfaction surveys.
- For Medicaid Managed Care—primary care practitioners must adhere to specific member-to-PCP ratios. These ratios assume that the practitioner is a full time equivalent (FTE), defined as a provider practicing forty (40) hours per week:
  - No more than 1,500 enrollees for each physician, or 2,400 for a physician practicing in combination with a registered physician assistant or a certified nurse practitioner.
  - No more than 1,000 enrollees for each certified nurse practitioner
  - These ratios will be prorated for participating providers who represent less than a FTE.
Specialist Physician Responsibilities
The specialty care physician is responsible for responding to the referral from the primary care physician. Those responsibilities include but are not limited to the following:

- Support and comply with the terms of BlueCross BlueShield provider agreement.
- Provide care that is medically appropriate and proficiently delivered to produce optimal patient outcomes and satisfaction.
- Be available 24 hours a day, seven days a week or arrange coverage with a participating physician to provide patient access during his or her absence.
- Work closely with the primary care physician to enhance continuity of health services.
- Advise the PCP of any ongoing treatment program and if another specialist is needed.
- Demonstrate his or her commitment to the patient-physician relationship as evidenced by communicating effectively the recommended medical treatments and/or lifestyle changes to patients, while maintaining ongoing communication with the PCP to ensure continuity of care.
- Collect specified copayments from members for office visits.
- Cooperate with all BlueCross BlueShield policies and procedures, and demonstrate a willingness to examine his/her practice patterns as they pertain to feedback from the health plan.
- Maintain an office that is clean, accessible, safe, supportive of patient's needs and supportive of the health plan's policies and procedures. If offices and/or facilities are not wheelchair accessible, the practitioner must provide a documented plan of how wheelchair dependent patients are accommodated.
- Agree to comply with the terms of the health plan's preauthorization and credentialing requirements as well as all other contract terms, policies and procedures and protocols.
- Ensure the confidentiality of members' medical records.
- Maintain current credentialing standards.

On-Call Coverage Requirements
Providers should make arrangements with other participating providers to ensure that BlueCross BlueShield members have access to health care 24 hours per day, seven days per week. An "on-call provider" covers for another. The name of the on-call providers should be indicated on the provider application form at the time of credentialing and re-credentialing. Please see the attached (Appropriate Coverage Arrangements for PCPs).

Providers should follow the guidelines below when selecting providers to cover their practices:
A. Individual provider practices are limited to five on-call providers.
B. All providers of the same specialty within a group can be on call for each other.
C. Specialists cannot be on call for PCPs.
D. Specialists can only be on call for specialists in the same field.
E. All on-call providers must be participating providers with BlueCross BlueShield.
It is the responsibility of the provider to notify the File Data Management Department of any changes to who is covering for his/her practice. If a provider is covering on a temporary basis only, Provider File Data Management should be notified of the specific dates that he/she will be covering.

Appropriate Coverage Arrangements for PCPs

The following criteria explain that family practice physicians must have a coverage agreement for each major component of their active practice with a physician that has an active practice in the same component (adult medicine, pediatrics, and OB-GYN). It may be necessary for the family practice physician to have more than one practitioner for coverage agreement(s) for their active practice(s) as described in the table below. Pediatric practice physicians must have coverage agreement(s) with physicians that have an active pediatric component within practice(s).

Adult medicine physicians must have coverage agreement(s) with physicians that have an active adult medicine component within their practices.

<table>
<thead>
<tr>
<th>Adult Medicine</th>
<th>Pediatric Medicine</th>
<th>Family Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the following may cover for each other for adult medicine:</td>
<td>A Pediatrician must have either of the following:</td>
<td>Family Practice physician with an active practice of adult medicine must have the following cover for each other for adult medicine:</td>
</tr>
<tr>
<td>Internal Medicine Family Practice General Practice</td>
<td>A Pediatrician</td>
<td>Internal Medicine Family Practice General Practice</td>
</tr>
<tr>
<td>If a Family Practice physician has an obstetric practice, the practitioner must have either of the following:</td>
<td>Or</td>
<td>And</td>
</tr>
<tr>
<td>OB-GYN cover for the obstetric portion of his practice</td>
<td>A Family Practice Physician that has an active pediatric practice.</td>
<td>Family Practice Physician with a pediatric practice must have either of the following:</td>
</tr>
<tr>
<td>Or</td>
<td></td>
<td>A Pediatrician</td>
</tr>
<tr>
<td>A Family Practice physician that has an active obstetric practice.</td>
<td>Or</td>
<td>Or</td>
</tr>
<tr>
<td></td>
<td>A Family Practice physician that has an active pediatric practice.</td>
<td>A Family Practice physician with an obstetric practice must have either of the following:</td>
</tr>
</tbody>
</table>
It is important to notify BlueCross BlueShield Provider File Data Management Department concerning any additions or deletions of on-call physicians. Notifying us about an on-call relationship before services are rendered helps eliminate claim denials for treatment delivered by that provider. If another provider will be covering for you on a temporary basis only, please inform our Provider File Data Management Department of the specific dates he will be covering. Members often call our Member Service Department regarding coverage for their PCP. If we have a provider listed as a covering physician for you and the information is incorrect, the patient will not have access to care in your absence.

Properly Terminating the Physician-Patient Relationship
When a physician begins to care for a patient, the physician is obligated to continue to provide care to the patient as long as the patient needs treatment. A physician may terminate the relationship provided the physician gives the patient reasonable notice and a sufficient opportunity to make other arrangements for care. Otherwise, the physician may be guilty of abandonment, resulting in a malpractice judgment or disciplinary action.

To avoid a malpractice claim or possible disciplinary action, the American Medical Association (AMA) recommends a physician take the following steps to terminate the physician-patient relationship:

1. Give the patient written notice, preferably by certified mail, return receipt requested;
2. Provide the patient with an explanation for terminating the relationship;
3. Agree to continue to provide treatment and access to services for a reasonable period of time, 30 days for care, 60 days for emergent/urgent services, to allow the patient to secure care from another physician;
4. Provider resources and/or recommendations to help the patient locate another physician of a like specialty;
5. Offer to transfer records to a newly designated physician upon signed patient authorization to do so.

We further recommend placing a copy of the written notice in the patient's chart and clearly stating in the chart after the last visit that the patient is no longer seeing the
If a physician follows these steps, the fact of termination and the date of termination will be clear, making it unlikely the physician will be subject to a malpractice suit or professional discipline for abandoning the patient. Physicians should be aware; however, that properly terminating a physician-patient relationship as set forth above may not insulate a physician from disciplinary action for having sexual contact with a patient.

As is illustrated in sexual contact cases, taking the steps outlined by the AMA may not actually terminate the professional relationship. In a sexual contact case, the Office of Professional Medical Conduct will look to see if the physician took formal steps to terminate the relationship and will closely examine the nature of the professional relationship in order to determine whether the professional relationship has actually been terminated.

New York State has their policy statement on Physician Sexual Misconduct on the Internet at health.state.ny.us/nysdoh/opmc/miscon.htm; or, to request a copy, call 1-800-663-6114.

If you would like examples of letters that terminate a physician-patient relationship, please contact the Credentialing Department at (716) 887-7500.

Hospital-based Provider Credentialing Process
Certain providers who are subject to credentialing and are hospital-based will be considered an active participating provider upon receipt of an executed participating provider agreement. Currently, hospital-based providers include the following specialties:

- Anesthesiologists who provide basic anesthesia services only
- Certified registered nurse anesthetist (CRNA)
- Emergency room (ER) physicians
- Hospitalists
- Pathologists
- Physician assistants and nurse practitioners who provide only hospital-based services

Hospital-based providers will be required to meet all credentialing criteria as defined in this provider manual. Hospital-based physicians are not reviewed as part of the re-credentialing process as long as they maintain their hospital privileges.

Provisional Credentialing
Effective October 1, 2009, BlueCross BlueShield of Western New York updated its credentialing policy concerning the application process for credentialing newly licensed health care professionals (HCP) or HCPs relocating from another state, who are joining a group practice of in-network providers.

An HCP joining a group practice can be considered a “provisionally” credentialed provider on the ninety-first day after submitting a complete application to BlueCross
BlueShield. If we do not approve or decline the application within 90 days, this status will continue until we either credential the provider or decline the application. During this provisional period the HCP is considered an in-network provider for the provision of covered services to members, but may not act as a primary care provider (PCP).

The law further states that if the application is ultimately denied, the provider will revert back to non-participating status. The group practice wishing to include the newly licensed or relocated HCP must agree in writing, prior to the provisional status becoming effective, to refund any payments made by BlueCross BlueShield for in-network services delivered by the provisionally credentialed HCP that exceed any out-of-network benefit.

In addition, the provider group must agree to hold the member harmless from payment of any services denied during the provisional period except for collection of copayments that would have been payable had the member received services from an in-network provider.

Other Guidelines
Fraud Waste and Abuse (Medicare and Medicaid)
Your contract with us requires you to comply with specific policies to detect and prevent fraud, waste, and abuse.

Per state and federal regulations, as noted in the New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts in your Agreement, you must send us details on the following items:

- Disclose to the plan the identity of any person affiliated with the provider (owner/person with control interest, agent or managing employee) who has been convicted of a criminal offense related to that person’s involvement in Medicare, Medicaid or Title XX services programs. Monitor your managing employees and agents monthly against the following websites:
  - Office of the Medicaid Inspector General (OMIG) at omig.ny.gov.
  - List of Excluded Individual and Entities - Office of Inspector General (OIG) at exclusions.oig.hhs.gov
  - System for Award Management (SAM) at sam.gov

- Report to us monthly any individuals that were found to be on the exclusions list(s).

- Upon request made by the New York State Department of Health (NYSDOH), Office of Medicaid Inspector General (OMIG), or Department of Health and Human Services (DHHS), you must obtain ownership information from any subcontractor with whom you had a transaction totaling more than $25,000 during the 12-month period ending on the date of the request.

  - You must send a copy of the information to us within 35 days of such request.

You are also obligated to:

- Disclose complete ownership, control, and relationship information. In accordance with state and federal regulation, we are required to obtain a Disclosure of Ownership and Control form from contracted providers rendering services to our members.
• Maintain and make available, upon request and at no charge, records related to monthly monitoring and reporting of criminal convictions and exclusions.

The Practitioner/Facility Disclosure of Ownership and Control form is located on our website at bcbswny.com/provider

Exclusion Checks
Providers of health care services are required to perform exclusion checks by CMS 42 C.F.R. §422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 1001.1901, and §1862(e)(1)(B). The Medicare Managed Care Manual Chapter 21 states the following:

“Sponsors must review the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties Lists System (EPLS) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or FDR, and monthly thereafter, to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs. Monthly screening is essential to prevent inappropriate payment to providers, pharmacies, and other entities that have been added to exclusions lists since the last time the list was checked. After entities are initially screened against the entire LEIE and EPLS at the time of hire or contracting, sponsors need only review the LEIE supplement file provided each month, which lists the entities added to the list that month, and review the EPLS updates provided during the specified monthly time frame.”

Preclusion List (Medicare)
Centers for Medicare & Medicaid Services (CMS) will make available a Preclusion List to BlueCross BlueShield as a Medicare Part D sponsor and Medicare Advantage Organization (MAO).

Individuals or entities that fall within the following criteria will appear on the list:

- Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or

- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

In accordance with Title 42 of the Code of Federal Regulations (CFR) Part 422.222 and 422.224, a MAO must not make payment for a health care item or service furnished by a provider included on the Preclusion List. Therefore, no payment can be made, directly or indirectly, on any basis, for any item or service furnished to a Medicare enrollee by a precluded individual or entity. Additionally, Medicare plans must remove any contracted provider, who is included on the Preclusion list, from their network.
As a MAO, BlueCross BlueShield is required to ensure that our contracted providers are properly credentialed and not on the Preclusion List. Additionally, when periodically re-validating credentialed providers, we are required to again confirm that our contracted providers are not included on the Preclusion List.

Included below is a link to the CMS site describing the Preclusion List.

cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html

Non-discrimination Policy
Participating physicians and providers have a policy and procedure in place and agree not to differentiate or discriminate against members in the delivery of health care services based on, but not limited to: race, ethnicity, national origin, religion, sex, age, mental or physical disability, medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

The hours of operation that practitioners offer to Medicaid members must be no less than those offered to commercial members.

Provider Directory Data Accuracy
Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) began enforcing regulations about changes in the Medicare program regarding accurate provider directory information.

As a participant in the Medicare program, BlueCross BlueShield of Western New York is required to adhere to CMS regulations, including displaying provider practice information in our provider directories and the Find a Doctor search tool on our website.

If your contact information is not accurate, our members could have difficulty scheduling appointments and receiving medical services from you; therefore, we will be contacting you on a quarterly basis to validate your contact information. The following information will be verified:

- Practitioners at all locations
- Specialties
- Street address
- Phone number
- NPI
- Tax Identifier
- Practice Fax
- Practice Manager email
- Patients availability to schedule appointments timely
- Provider accepting new patients
- Provider on-call or covering at location
- Enrollment status with Medicare
• Practice name
• Hospital affiliation
• Provider type

Please review your current information at bcbswny.com/provider and ensure that it is accurate.

If you need to make any changes, please provide them via the Provider Demographic Change Form located on our website under Provider > Tools & Resources > Forms.

Changes in Status
Physicians are contractually obligated to promptly notify BlueCross BlueShield, in writing, if there are any changes to their practice. Please refer to your Participating Physician Agreement, Section 2.6 Notification.

Physicians must notify BlueCross BlueShield within 30 days if and when any of the information submitted in the most recent application changes. If a practitioner is no longer participating and wishes to be reinstated, that practitioner must reapply and go through the full credentialing process if the break in participation is 30 days or more. The Credentialing Committee must review all credentials and make a final determination prior to the practitioner's re-entry into the network. A Demographic Change Form, which can be used to notify us when your office location changes (open/close, addition) or when an update for a tax identification number is needed, can be found on our provider website. Physicians are also required to notify their BlueCross BlueShield patients, within 72 hours, of any changes in office hours, location, and/or phone number. BlueCross BlueShield will complete your demographic update request within 30 days of receipt.

Members Seeking Care in an Inpatient/Outpatient Setting
Every member seeking services both in an inpatient and outpatient setting is afforded the right to request the services be performed by their attending physician of record.

Medical Records, Information and Confidentiality Policies
BlueCross BlueShield is entitled to receive from any provider who renders service to a member all information reasonably related to the terms of their contracted agreement. Subject to applicable confidentiality requirements, members authorize any provider rendering service to disclose all facts pertaining to such member's care and treatment by the provider and to permit copying of such reports and records by the health plan. This authorization is obtained during the member's enrollment.

Confidentiality
BlueCross BlueShield will preserve the confidentiality of the member’s health and medical records consistent with the requirements of applicable New York State and federal law.

BlueCross BlueShield’s confidentiality policy expects that the physicians will maintain confidentiality of all materials and records that are proprietary to BlueCross BlueShield or are used in connection with BlueCross BlueShield’s credentialing, reimbursement,
quality assurance or other peer review programs, in accordance with the terms of the physician's application form and contract with BlueCross BlueShield and the requirements of state or federal law.

Confidentiality of behavioral health and substance use information

BlueCross BlueShield requires each health care provider to develop policies and procedures to assure confidentiality of MH/SU related information that includes:
(a) Initial and annual in-service education of staff, contractors
(b) Identification of staff allowed access and limits of access
(c) Procedure to limit access to trained staff (including contractors)
(d) Protocol for secure storage (including electronic storage)
(e) Procedures for handling requests for BH/SU information protocols to protect persons with behavioral health and/or substance use disorder from discrimination

Records
The health plan keeps records of all members, but will not be liable for any obligation dependent upon information from the group or members prior to its receipt in a form satisfactory to the health plan. If the health plan has not acted to its prejudice by relying on incorrect information furnished by the group or members, such information may be corrected.

Provider Education and Support

On-site/Medical Records Reviews: Additional/New Office Location
An on-site review and medical record review will be completed when the practitioner relocates or opens a new practice.

Imaging Provider Accreditations Requirements

Imaging Accreditation Standards
The following guidelines are proprietary and confidential.

As part of our ongoing efforts to maintain quality provider panels, BlueCross BlueShield requires specific quality standards be met by imaging services providers for continuing participation in our network. These standards have been developed by national professional societies and are accepted across the country. These standards primarily apply to the following services:
- MRI
- MRA
- CT and PET/CT
- CTA and CCTA
- PET
BlueCross BlueShield requires that imaging facilities and service providers acquire and maintain accreditation for the modalities provided. Providers can receive accreditation by completing either of the following accreditation programs:

- American College of Radiology (ACR)
- Intersocietal Commission for the Accreditation of Magnetic Resonance Imaging (IAC)

Details for accreditation programs are available at their respective websites – https://www.acraccreditation.org, https://www.intersocietal.org/mri/

All practitioners must maintain current BlueCross BlueShield credentials in order to continue as participating imaging network practitioners.

Should we become aware that a specific modality/modalities are non-compliant with their accreditation status, claims paid to the provider for all imaging services provided from the time of the accreditation expiration through the date of renewal of the accreditation, will be retracted. Note: these services remain the provider’s responsibility and cannot be billed to the patient.

In addition, it will be mandatory for all imaging providers and facilities to:

- Provide a verbal report within three business days and a written report within seven business days from the date of service to the ordering provider for routine services. Urgent studies require a verbal report on the same day of service and a written report within five business days. Mammography reports must be completed within 30 days, per Mammography Quality Standards Act (MQSA) guidelines.
- Have a documented quality control program inclusive of both imaging equipment and film processors.
- Have a documented radiation safety program and ALARA (As Low As Reasonably Achievable) Program.
- Have a current (within three years) letter of state inspection, calibration report or physicist’s report (if applicable) if utilizing equipment producing ionizing radiation.
- Have documented compliance with all state and regulatory requirements.
- Assure that any and all covered imaging services (not just MRI, MRA, CT, CTA and PET) must be provided on imaging equipment (i) owned by the provider or (ii) leased by the provider on a full-time basis. Owned or leased on a full-time basis is defined as (a) the practitioner has possession of the equipment on the practitioner’s property and the equipment is under the practitioner’s direct control and (b) the practitioner has exclusive use of the equipment, such that the practitioner and only the practitioner uses the equipment.
- Assure that all contrast enhanced procedures must be performed under the attendance and direct supervision of a BlueCross BlueShield credentialed imaging provider and New York State licensed physician. The clinical staff or technicians must have current Basic Life Support (BLS) certification (ACLS certification is highly recommended).
- Be staffed on-site by a BlueCross BlueShield credentialed practitioner, board-certified within a specialty whose scope and expertise is related to the study being
Have studies they have performed interpreted and reported on by a BlueCross BlueShield credentialed diagnostic radiology or nuclear medicine practitioner.

- Assure staffing such that they employ a minimum of one American Registry of Radiologic Technologists (ARRT) certified technologist on a full-time basis at each site.

- Ensure that providers performing PET are board certified in diagnostic radiology, nuclear medicine or nuclear cardiology along with technologists certified in nuclear medicine through ARRT, CNMT or NMTCB.

- Be subject to unannounced site inspections. Providers, who are found to have misrepresented information on their application or to be noncompliant with any of the above criteria, will be subject to termination.

- Accept that global billing of imaging services is required. Only the practitioner performing the imaging study is permitted to bill for the service.

- Participate in periodic over-reads of studies selected by the plan by an independent radiologist as part of the plan’s quality assurance program as identified by the plan.

In accordance with the BlueCross BlueShield agreement, practitioners must notify us in the event there is a material change to or within a practice. BlueCross BlueShield reserves the right to revoke any granted privileges if the obligations of the practitioner contract are not adhered to. Practitioner privileges will be terminated at the time a BlueCross BlueShield practitioner contract is terminated.

- Agree that BlueCross BlueShield medical policy will apply to the delivery of services detailed in the criteria.

### Cone Beam CT Scanners

Services for Cone Beam CT scanners are **not eligible** for reimbursement. Full-service CT units must be a minimum of four-slice. In addition to the updated standards, all other criteria noted previously must continue to be met.

<table>
<thead>
<tr>
<th>Applies To</th>
<th>Metric</th>
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</table>
| MRI and MRA | - ACR Accreditation or IAC must be obtained and maintained  
- Must provide **full body** scanning capability (“total service”). Machines must have been manufactured after January 1, 2002 to qualify.  
- Devices with field strength of 1.0T must have parallel processing capability. Otherwise, the device will be limited to performing examinations of the brain, spine, and extremities.  
- Devices with field strength of less than 0.3T will not be permitted.  
- Devices with field strength of 1.5T or greater will be permitted to perform all examinations, including angiographic, Magnetic Resonance Cholangiopancreatography (MRCP) and breast |
### CT, CTA, CCTA, and PET/CT

- ACR or IAC Accreditation must be obtained and maintained
- A full service CT unit must demonstrate helical or spiral image acquisition capability.
- CTA of lower extremities requires a minimum of 16 slices per rotation.
- CCTA, when approved, will require a minimum of 64 slices per rotation.
- Cone Beam CT scanners are not accepted.
- These standards apply to any diagnostic CT studies performed on a PET/CT device

### PET

- ACR or IAC Accreditation must be obtained and maintained
- Only high performance full ring PET systems will be considered.
- Sodium iodide detector systems are not acceptable.
- PET equipment must be fusion capable. Equipment and related workstations must have the ability to register PET and CT information as a single image

### Mobile Services

- Will not be considered except for FDA certified mammography or in a SNF or hospital setting using mobile services.

**Proprietary and Confidential**
Section 3 - Referral Management

- Effective January 1, 2003, referrals were no longer required for BlueCross BlueShield HMO members. This means that primary care physicians can refer BlueCross BlueShield members directly to an in-network specialist without contacting the health plan for approval.

- Effective January 1, 2009 referrals were no longer required for Senior Blue HMO members. This means that primary care physicians can refer BlueCross BlueShield members directly to an in-network specialist without contacting the health plan for approval.

- Referrals are no longer required for Healthy New York, Essential Plan as well as certain Traditional POS plans effective September 1, 2018.

What is HEALTHeNET (wnyhealthenet.com)

HEALTHeNET is a HIPAA-compliant health information network that offers physicians, providers, and office staff access to a patient's health information using simple and fast, web-based transactions.

The following set of transactions that are available online:

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Transaction (270/271)</td>
<td>By using HEALTHeNET, you can confirm your patients' eligibility, primary care physician, correct copay, and benefits in just seconds.</td>
</tr>
<tr>
<td>Claim Status Transaction (276/277)</td>
<td>This feature will allow you to check the status of your claims, eliminating the need to contact the Customer Service Department.</td>
</tr>
</tbody>
</table>

We encourage you to sign up today to use this tool by completing the online enrollment form located at wnyhealthenet.com.

Urgent Care

Urgent Care is medically necessary treatment that requires prompt attention and is not an emergency. Members are covered for urgent care when away from home through the BlueCross BlueShield national network.

Members will call the PCP for guidance, and if treatment is advised, the member will call 1-800-810-2583 to locate a provider in the BlueCross BlueShield national network. The member will make an appointment and present their home plan membership card.
Emergency Care
BlueCross BlueShield does not preauthorize emergency services and we do not deny emergency care on a retrospective basis, however, we may identify specific diagnosis to pend for medical review to determine if rationale to seek care in an emergency room setting meets the intent of the New York State Prudent Layperson Law. After review by a physician, BlueCross BlueShield will treat identified non-emergency care as an adverse determination and all provisions of Adverse Determination Policy will be applied.

Emergency services, including Comprehensive Psychiatric Emergency Program (CPEP) and Office of Mental Health/ Office of Alcoholism and Substance Abuse Services (OMH/OASAS) Crisis Intervention and OMH/OASAS specific non-urgent ambulatory services are not subject to prior approval.

Definition of Emergency Care
Emergency condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, 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; or (d) serious disfigurement of such person.
Section 4 – Administrative and Out-of-Plan Referrals

Administrative Referrals

The Medical Director, the Director of Utilization Management or a nurse reviewer may issue an administrative referral for continuity of care or as medically necessary under the following conditions:

- A new member requires specialty care, but the PCPs office cannot accommodate a new member visit immediately.
- A new member changes PCPs and current referrals are terminated, but continued specialty care is required.
- Continuation of active care occurs under the following circumstances:
  - If the provider's participation terminates, the member may continue to receive care for up to 90 days. The 90 day transitional period begins on the date the provider’s contractual obligation with the health plan to provider services terminates.
  - If the member is in the second or third trimester of pregnancy, she may continue receiving care from a terminated provider through delivery and the postpartum period.
  - New enrollees in the second or third trimester of pregnancy may continue to see out-of-network providers for delivery and postpartum care.
  - New enrollees who are disabled, or have degenerative and/or life-threatening conditions or diseases, may continue to see out-of-network providers for up to 60 days from the date of enrollment.

Specialty Care Coordinators

Certain medical conditions require a specialist or specialty-care center to provide and/or coordinate the member's primary and specialty care. In these cases a specialty care coordinator (SCC) may be designated. The Medical Director must approve the designation of SCC.

The SCC does not require a referral from the primary care physician (PCP) and may authorize referrals, procedures and other medical services to the same extent the primary care provider would be able.

Such referral shall be made pursuant to a treatment plan developed by a specialty care center and approved by the HMO, in consultation with the primary care provider, if any, or specialist. Among other things, the treatment plan may set time limits on the SCC's authority or may establish the scope of services that may be provided or authorized by the SCC. To be eligible for care by a Specialty Care Center, the member must be afflicted with the following, which will require specialized medical care over a prolonged period of time:

- A life threatening condition or disease, or;
- A degenerative and disabiling condition or disease.
Diagnoses that may be classified as degenerative and disabling conditions may include but are not limited to:

- Cancer
- Cerebral Palsy
- Conditions necessitating an organ transplant
- Cystic fibrosis
- Hemophilia
- HIV/AIDS
- Multiple Sclerosis
- Sickle Cell Anemia

A Specialist Care Coordinator may be requested by:

- the member (upon enrollment)
- the member’s current PCP
- the member's specialist

A Specialist Care Coordinator who is not a participating provider will only be approved if the Medical Director determines that we do not have a provider in the network with the appropriate training and expertise to provide the care necessary, and that a Specialist Care Coordinator is required and appropriate.

Members receiving care by a Medical Director-approved Specialty Care Center that is a non-participating provider, cannot be required to pay any more out-of-pocket expense than they would have when treated by a participating provider.

Summary of Specialty Care Coordination Process

1. Request for Specialist Care Coordinator.
2. Utilization Management (UM) reviews patient history and discusses request with patient, PCP, specialist, and Medical Director.
3. Decision is rendered with one of the following options:
   - Maintain PCP, but allow one year referral to specialist
   - Request new PCP with appropriate sub-specialty
   - Request SCC for patient
4. Letter sent to member, provider and specialist with decision determination.

Specialty Care Centers

A Specialty Care Center is a center accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the disease or condition for which it has been accredited or designated. If we determine that our provider network does not have a Specialty Care Center with the appropriate expertise to treat a member's disease or condition, the member's PCP may request a referral to a non-participating provider. To request a referral, the PCP may contact our Utilization Management Department at 1-800-677-3086.

Summary of Specialty Care Coordination Process:

1. Request for Specialty Care Coordinator.
2. Utilization Management (UM) reviews patient history and discusses request with patient, PCP, specialty, and Medical Director.

3. Decision is rendered with one of the following options:
   - Maintain PCP, but allow one year referral to specialist
   - Request new PCP with appropriate sub-specialty
   - Request SCC for patient

4. Letter sent to member, provider and specialist with decision determination.

If we determine that a member's disease is life-threatening, or degenerative and disabling, and will require specialized medical care over a prolonged period of time, we will authorize an in-network referral to a Specialty Care Center that has the expertise to treat the member's disease or condition.

**Out-Of-Plan Referral**

Out-of-plan (OOP) referrals for urgent care are made to providers or facilities not participating with BlueCross BlueShield when:

- the member is outside the BlueCross BlueShield service area
- participating providers in the area cannot provide the necessary services

OOP referrals are made by the PCP or specialist and require review by the Utilization Management Department.

If you believe that the service is materially different then what is available in-network we require:

1. a written statement from the enrollee's attending physician, who must be a board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service requested, that the requested out-of-network health service is materially different from the health service the health care plan approved to treat the insured's health care needs; and
2. two documents from the available medical and scientific evidence that the out-of-network health service is likely to be more clinically beneficial to the enrollee than the alternate recommended in-network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

If you believe that there is not an appropriate in-network doctor who can provide the service needed, we require a written statement from you explaining:

1. Why in-network doctors do not have the appropriate training and experience to meet particular needs; and
2. Why you recommend an out-of-network doctor who has the appropriate training and experience and is able to provide the service.
You must be licensed and board certified or board eligible, and qualified to practice in the specialty area appropriate for the treatment needed.

The member’s care should be directed to an in-network provider as soon as his or her condition(s) permits it.

**Examples of Out-of-Plan Coverage**

OOP referrals are not made for patient convenience. The following circumstances must apply:

1. The covered service is not available from a participating in-network provider
2. A specialty provider is not available in-plan
3. Possible access issues

If the services are deemed necessary and are a covered service to a member in-network, the plan will adequately and timely cover these services for as long as the plan is unable to provide the service in-network.

Second opinions will also be arranged for a member should an appropriate professional not be available in-network. This will occur at no more cost to the member than if the service was obtained in-network.

**Travel Time and Distance Standards:**
- 30 minutes or 30 miles for PCPs.
- For all other providers, it is preferred that they satisfy the 30-minute or 30-mile standard (not required).

This does not apply for patient convenience.

The above 30 miles/30 minutes travel time rule does not apply to a specialty M.D.

**Urgent Care**

Urgent Care is medically necessary treatment that requires prompt attention and is not an emergency. Members are covered for urgent care when away from home through the BlueCross BlueShield national network. **Referrals must be requested within 48 hours of services being rendered.**

Members will call the PCP for guidance, and if treatment is advised, the member will call 1-800-810-2583 to locate a provider in the BlueCross BlueShield national network. The member will make an appointment and present their home plan membership card. The PCP needs to contact BlueCross BlueShield to coordinate the required referral for out-of-area urgent care.
Section 5 - Utilization Management Overview

Program Objectives

BlueCross BlueShield’s Utilization Management (UM) Program is a dynamic process whose goal is to facilitate member health management throughout the continuum of care. The Program is tailored to meet the individual needs of our members for medical and behavioral health services. For additional information on our behavioral health program, see section 18.

Our Utilization Management staff uses an integrated process to help ensure access to care for both members and providers. The Utilization Management team, through the use of new technology, focuses on those providers, members or diseases to identify and facilitate the implementation of best practices in the delivery of quality, cost-effective care.

We:

• Identify barriers to care
• Monitor health care for under and over utilization
• Track cost effectiveness through trend analysis

The interventions we develop take into account local practice and changing technology. We work to enhance the health of our members by facilitating the improvement of clinical outcomes through mutually beneficial partnerships with providers.

We support our providers and members with valuable, trusted information to facilitate and jointly plan for the delivery of the right clinical care, in the most appropriate setting, at the right time, with the right provider and at a reasonable cost, without compromising quality.

The Utilization Management Program has nine primary objectives:

1. **Quality Care:** Provide quality care for our members throughout the health care continuum.
2. **Utilization Trends:** Analyze trends and patterns of utilization and, based on our analysis, recommend improvements to access and quality of care. Through trending we also identify those services that may require additional scrutiny.
3. **Medical Appropriateness:** Develop and apply standards and guidelines and ensure that our decisions are fair and consistent based on those standards.
4. **Service Appropriateness:** Monitor the appropriateness and outcomes of services that health care institutions, contracted physicians, and contracting non-physician providers supply to our members. Any questionable cases are forwarded to the Health Care Quality Improvement or Special Investigational Unit for review.
5. **Appeals Process:** Establish and maintain a mechanism for member appeal of adverse determinations, as defined by regulatory and legislative requirements.
We provide an appeal process to our providers as defined in their contract, and legislative changes.

6. **Corrective Actions:** In order to maintain high standards of quality and cost efficiency throughout the organization, we perform educational and other corrective actions to remedy identified deficiencies.

7. **Medical Care Delivery Initiative:** Continually evaluate the Health Delivery System to manage the changing philosophy of Utilization Management. We redesign our approach to managing care and structuring of our delivery system by:
   - Referring all cases that could value from a case/disease intervention for case and disease management.
   - Maximizing the advantage of information technology available to us.

8. **Vendor Oversight**
   BlueCross BlueShield delegates specific Utilization Management functions to a number of vendors. BlueCross BlueShield seeks to align with vendors who are an expert in their field and have attained national certifications.

   Our vendors maintain their own UM Program, which is approved by BlueCross BlueShield’s Vendor Joint Oversight Team and reports to the Quality Management Committee. Vendor physicians are involved in our clinical committees upon request. Utilization Management conducts yearly audits that include a review of policies, procedures and operational functions of the Utilization Management Department.

   File audits are conducted on a quarterly basis.

   - **HealthPlex (Dental)** - BlueCross BlueShield delegates specific dental management to HealthPlex for the Essential Plans. HealthPlex has NCQA certification.
   - **Palladian Health** - BlueCross BlueShield delegates specific spine pain management procedures to Palladian Health for select lines of business. Palladian Health is NCQA certified.
   - **Amerigroup** - BlueCross BlueShield delegates all Utilization Management to Amerigroup ONLY for Managed Medicaid and Child Health Plus (CHP) lines of business.

9. **Utilization Management Satisfaction Team:** The Utilization Management Department will evaluate the need for additional programs (or enhancement of current programs) to increase customer satisfaction at all levels, i.e., members, providers and employer groups.

### Utilization Management

**Purpose**
The Utilization Management Department follows a proactive care management model ensuring all our members:
• Timely access to quality care
• Enhanced opportunities for referrals to Case and Disease Management

It is the responsibility of Utilization Management staff to ensure quality care in the most appropriate setting for all members. Utilization Management staff provides all our members with comprehensive medical management by coordinating the processes of preauthorization and level of care review.

Treatment Plans
Utilization Management nurses are trained to discuss short- and long-term treatment plans, including social and environmental impacts on the healing process. Our nurses follow the Utilization Management philosophy of identifying potential chronic problems early and establishing a link with a case manager. When a specialized service or procedure is requested, the nurse interacts with the physician to select and implement preventive or supportive care using either individual case or disease management programs.

Discharge Planning
From the time of admission, we collaborate with discharge planning to ensure adequate time to initiate a safe and comprehensive plan of care.

Member and Provider Access
Nurses are available to review telephone requests and questions from BlueCross BlueShield members and practitioners/providers with regard to the Utilization Management process including treatment plan options, expedited appeals for adverse determinations, and access-to-care interventions.

During business hours
From 8:15 a.m. to 5 p.m., EST, Monday through Friday, a member or physician may call the Utilization Management Department at 1-800-677-3086 to speak with a nurse.
From 8:15 a.m. to 5 p.m., EST, Monday through Friday, a member or physician may call the Behavioral Health Utilization Management Department at 1-877-837-0814 to speak with a nurse.

• Staff will identify themselves by name, title and organization name when initiating or returning calls regarding Utilization Management issues.
• Staff has ability to place outbound communications regarding inquiries during normal business hours.

After business hours
Nurses and physicians are also available at 1-800-677-3086 for expedited appeals and urgent access to medical services.

• You may: Leave information for a return call the next business day or stay on the line and be forwarded to our exchange service. They will then take member and practitioners/provider information and contact the nurse on-call for urgent admissions and/or expedited appeals.
• For non-urgent services, requests received after business hours (5 p.m.) will be processed the next business day.

Note: Urgent/emergency admissions do not require preauthorization.

Criteria/Medical Appropriateness Review
BlueCross BlueShield conducts medical appropriateness reviews to determine the appropriateness of a service. A pre-admission review is performed prior to admission on the elective surgical procedure being performed (NOT level of care), concurrently during an episode of care, and retrospectively to determine that procedures are medically necessary and appropriate for a specific condition. If health services are approved, BlueCross BlueShield will not modify standards or criteria during the same course of treatment.

Medical Appropriateness Review Guidelines
The guidelines promote cost-effective allocation of medical resources by identifying cases that:
• May not reflect accepted medical process.
• May benefit from alternative treatment modalities or settings.

We follow both licensed (InterQual® Criteria) and Corporate Medical Protocols for medical appropriateness review.

Refer to the Corporate Medical Protocols in Section 8 for additional information.

Application of Guidelines
Application of the guidelines allows for quick approval for a defined number of members. It is the responsibility of care managers to collect relevant clinical information. If guideline requirements are not met, the physician reviewer must be consulted for final determination.

We consider at least the following factors when applying criteria to a given individual:
• Age
• Comorbidities
• Complications
• Progress of treatment
• Psychosocial factors
• Home environment, when applicable

We also consider characteristics of the local delivery system that are available for the particular member, such as:
• Availability of skilled nursing facilities, sub-acute care facilities, or home care in the BlueCross BlueShield service area to support the patient after discharge
• Ability of local hospitals to provide all recommended services within the estimated length of stay
• Coverage benefits
Coverage Decisions Based on Appropriateness of Care
BlueCross BlueShield bases its medical necessity decisions on the appropriateness of care and services. Coverage decisions are based on the benefits and provisions contained in members' contracts. BlueCross BlueShield does not reward or offer incentives to practitioners, providers or staff members for issuing denials or for encouraging inappropriate under-utilization of care.

Preauthorization Review
A preauthorization review is performed for:
- Select outpatient procedures
- Select durable medical equipment
- Certain medical/surgical benefits as notified by our Protocols or STAT Bulletins
- Elective hospital admissions for all facilities
- Admissions to rehabilitation and skilled nursing facilities
- Behavioral health inpatient & outpatient
- Home health care, if specified by contract
- Potential cosmetic procedures
- Potential experimental procedures
- Out-of-plan requests
- Select new technology

BlueCross BlueShield applies all medical appropriateness and appeal rights as per the New York State Department of Health (NYSDOH), New York State Department of Financial Services (NYSDFS), Federal Department of Labor (DOL), National Committee for Quality Assurance (NCQA) and Center for Medicare and Medicaid Services (CMS).

Urgent/emergency admissions do not require preauthorization. Once notified of admission, medical information is applied against InterQual® Criteria for level of care review.

Medical/Surgical Benefits
BlueCross BlueShield facilitates predetermination of benefit eligibility under the following conditions:
- When we receive a predetermination request
- When services or procedures may be a contract exclusion, such as cosmetic vs. reconstructive or dental vs. medical procedures

Medical Necessity Definition
Medical necessity 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.
We will reimburse for medically appropriate care that is not more costly than alternative services or supplies at least as likely to produce equivalent results for the person’s condition, disease, illness or injury.

**Level of Care Review**
Level of care review is conducted throughout a member's hospitalization through telephone, fax or on-site review using InterQual® criteria that includes the McKesson InterQual® Guidelines for Surgery and Procedures in the Inpatient setting list. Documentation of the member's clinical condition is essential to ensure the appropriate setting and level of care required.

If an initial review for level of care assignment is not conducted by the health plan and/or the information provided is inaccurate, lacking, missing or unavailable, BlueCross BlueShield reserves the right to perform a retrospective review to determine the level of care for reimbursement.

**Nurses’ Role**
Working in collaboration with the hospital's Utilization Review Department, BlueCross BlueShield's nurses obtain and review relevant medical information on-site or by phone/fax. The purpose of the review is to:

- Monitor service quality and access
- Assist in discharge planning
- Establish level-of-care determinations **using InterQual® criteria**
- Act as a resource to both the hospital and the physician
- Link members to case/disease management programs and community-based programs
- Assist physicians in identifying alternatives to continued hospitalization
- Help the facility, physician, or member exercise appeal rights when one of our physicians makes a level-of-care determination in accordance with the Adverse Medical Determination Policy

**Observation Level of Care**
Observation status, when used as an alternative to an acute hospital admission, is eligible for reimbursement for patients who meet InterQual® Observation criteria and require:

1. Further frequent cardiac, neurologic, or other physiologic monitoring and assessment
2. Evaluation or testing to determine a diagnosis
3. Extended definitive emergency department care and/or non-elective treatment (i.e., IV hydration, IV antibiotics)

A designated bed and/or unit are not required. For example, a patient in observation status may be located in an emergency room bed, medical bed, surgical bed, etc.

Services and treatment rendered in an observation bed are separate and in addition to emergency room services. An individual's dated and timed medical record must be maintained, including physician orders, progress notes, nurses' notes and the rationale for acuity evaluation status.
Observation services generally do not exceed, but are not limited to, 24 hours. The following do not qualify for Observation reimbursement:

- Services that do not meet InterQual® criteria
- Services for the convenience of the patient or physician
- Services not covered under the patient’s contract

**Maternity Admissions**
Preauthorization is not required for vaginal deliveries or cesarean section admissions within 96 hours of delivery. While preauthorization requirements have been removed to comply with the New York State mandate prohibiting preauthorization within 48 hours of delivery, BlueCross BlueShield fully expects that only appropriate and medically necessary services will be rendered. BlueCross BlueShield reserves the right to conduct post-payment reviews to assess the medical appropriateness of the aforementioned procedures rendered for benefit coverage.

**Rehabilitation and Skilled Nursing Facilities**
Admissions to both rehabilitation and skilled nursing facilities are covered if the following conditions are met:

- Preauthorization is mandatory prior to arranging admission to a participating facility
- The condition, illness, or injury meets medical necessity
- The terms and conditions of the BlueCross BlueShield contract are in effect

**Ambulatory Surgery**
Ambulatory surgery procedures will not be considered for inpatient reimbursement unless there is evidence using InterQual® criteria which includes the McKesson InterQual® Guidelines for Surgery and Procedures in the Inpatient setting list. Please refer to the protocol section of this manual when billing ambulatory surgery services.

NOTE: Post payment audits may be performed to ensure appropriate care is provided to our members.

**Urgent Care**
BlueCross BlueShield defines urgent care as medical care or treatment for which failure to make an expeditious determination could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that can't be adequately managed without the care or treatment requested.

Urgent Care requests that are received will follow the Federal guidelines in respect to timeframes. A response will be rendered within 72 hours if all necessary information is received at the time of the initial request.

In accordance with Federal guidelines, response to Urgent Care requests will be rendered within 72 hours, if all necessary information is received at the time of the initial request.
To efficiently assist our providers, urgent requests due to schedule changes or unforeseen circumstances, will be handled as routine requests and handled within three business days, *if all medical information is received at the time of the request*.

If medical records are not provided, requests will be handled within three business days of receipt of appropriate medical information.

BlueCross BlueShield's Away From Home Program covers a member for urgent care when away from home. Members needing out-of-area urgent care should contact their PCP for guidance to care. All provisions of the Urgent Care Out-of-Area policy will apply.

**Emergency Care Definition**

Emergency care is defined as the sudden onset of a medical or behavioral condition that manifests itself by symptoms of sufficient severity, including severe pain. In this situation, a prudent layperson with an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in one or more of the following:

- Placing the health of the person afflicted with the condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement

BlueCross BlueShield does not preauthorize emergency services and we do not deny emergency care on a retrospective basis; however, we may identify specific diagnoses to pend for medical review to determine if the rationale for seeking care in an emergency room setting meets the intent of the New York State Prudent Layperson Law. After review by a physician, BlueCross BlueShield will treat identified non-emergency care as an adverse determination and all provisions of Adverse Determination Policy will be applied.

Emergency services, including Comprehensive Psychiatric Emergency Program (CPEP) and Office of Mental Health/Office of Alcoholism and Substance Abuse Services (OMH/OASAS) Crisis Intervention and OMH/OASAS-specific non-urgent ambulatory services are not subject to prior approval.

**Time Frames for Preauthorization Review**

The following timeframes must be met for preauthorization reviews:

1. Non-Urgent Care
   - (Pre-service claims) A decision is made within three business days of obtaining all necessary information
   - Notification for approvals and denials are made to the member or the member's designee and the member's health care provider by telephone and in writing

2. Urgent Care
(Pre-service claims) A decision is made 72 hours after receipt of request.
Notiﬁcation for approvals and denials are made to the member or the member's
designee and the member's health care provider by telephone and in writing.

3. Concurrent Care
A decision is made within 24 hours or one business day (whichever occurs ﬁrst)
after receipt of request.
Notiﬁcation for approvals and denials are made to the member or the member's
designee, which may be satisﬁed by notice to the member's health care provider,
by telephone and in writing.

4. Post-Service
A decision is made within 30 days after receipt of the necessary information.
Notiﬁcations for denials are made to the member or the member's designee and
the member's health care provider in writing.

For Medicare Advantage
Standard Organization Determinations
A decision is made as expeditiously as the member's health condition requires, but no
later than 14 calendar days after receipt of request. A 14 calendar day extension may
be issued if the plan requires additional medical information to render a decision or the
member, designee or provider requests an extension.

Expedited Organization Determinations
A decision is made as expeditiously as the member's health condition requires, but no
later than 72 hours after receipt of request. A 14 calendar day extension may be issued
if the plan requires additional medical information to render a decision.

Appeal Rights for Preauthorization Review
Preauthorization review denials may be appealed:

- In the event of adverse determination the Medical Director or physician designee
  (clinical peer reviewer) is available to discuss the reasons for the denial.
- If the Medical Director fails to communicate with the requesting provider, the
  provider can request reconsideration.
- Failure to comply with timeframes for initial determination is treated as an
  adverse determination, which the member may appeal. Notice must be sent on
  the date review timeframe expires.

Adverse Medical Determinations
Only physicians (clinical peer reviewer) may render adverse medical determinations.
Adverse determinations may be appealed following the adverse medical determination.

Notice of Adverse Determination
Both the member and the provider are notiﬁed of any adverse determinations. The
notice of adverse determination must:
- Be made both verbally and in writing to the member and to the practitioner.
• Include rationale underlying any finding that the service was not medically necessary in easily understandable language and the clinical review criteria used to make the decision.
• Include the availability of the physician reviewer.
• Instructions on how to request a copy of the clinical review criteria used to make the determination or the clinical determination of the physician reviewer.
• A description of appeals rights (standard and expedited appeals) including the right to submit written comments, documents, or other information relevant to the appeal.
• An explanation of the appeals process, including the right to member representation and timeframes for deciding appeals and eligibility for external appeals.
• Include the phone number of the Plan contact for external appeal, if applicable to the member’s contract.
• Include the toll-free phone number of the DOH and/or the DOI, if applicable to the member’s contract.
• What additional information, if any, would be necessary to render a decision on appeal.

For Medicare Advantage Members
Medicare Advantage members are entitled to certain appeal rights pertaining to disputes about payment for, or failure to arrange (or continue to arrange) for, what the member believes are covered services (including non-Medicare covered benefits) under Medicare Advantage.

A member may appeal any adverse initial organizational determination.

A participating Medicare Advantage provider who is party to the appeal because they provided the service cannot file a Request for Reconsideration (Appeal). If health services are approved, Medicare Advantage will not modify standards or criteria during the same course of treatment. For further information on this process refer to Appendix 1.

Reconsideration Review
If attempts to discuss with the provider an initial adverse determination by the Plan’s Medical Director are unsuccessful, the provider may request reconsideration. Except in cases of retrospective reviews, such reconsideration shall take place within one business day of the request. The provider is expected to share information via telephone and fax to provide the reviewer with complete information regarding the case. Once the necessary clinical information is received, reconsideration is conducted by the member’s health care provider and clinical peer reviewer.

BlueCross BlueShield may reverse a preauthorized treatment, service or procedure on retrospective review when:
• Relevant medical information presented upon retrospective review is materially different from the information that was presented during the preauthorization review; and
• The information existed at the time of the preauthorization review but was withheld or not made available; and
• The clinical reviewer was not aware of the existence of the information at the time of the preauthorization review; and
• Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Utilization Management Appeal Process

The Utilization Management Appeal Procedure is designed to insure a timely review of denied services or treatments to determine whether the services or treatments are:

(i) Medically necessary;
(ii) Experimental or investigational in nature;
(iii) Cosmetic in nature;
(iv) Or, in certain cases, out-of-network.

A member or the member’s designee may appeal an out-of-network denial by submitting (a) a written statement from the member’s attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health service sought, that the requested out-of-network health service is materially different from the health service the health care plan approved to treat the member’s health care needs; and (b) two documents from the available medical and scientific evidence that the out-of-network health service is likely to be more clinically beneficial to the member than the alternate recommended in-network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

Under the Utilization Management Appeal Procedure, the right to appeal an adverse determination on a medical necessity basis or an experimental/investigational basis will be made available to the member, or their designated representative, which could be their provider. An adverse determination based on contractual language should be forwarded to the Grievance Department.

To improve accuracy and consistency, the UM appeals team administers the Utilization Management appeals process described below and provides support to Member Services for all grievances that require input from Utilization Management.

The right to appeal an adverse determination is made available to all members or their designated representative, which could be their provider. Providers may appeal retrospective UM denials on their own behalf.

The appeal process is an appeal of an adverse determination, whether standard or expedited. The determination of an appeal on a clinical matter will be made by personnel qualified to review the appeal, including who did not make the initial determination and who are not a subordinate of the individual who made the initial determination.
To submit verbal and/or written appeal requests, contact us at:

Phone: 1-800-677-3086 (toll-free)
Address: Utilization Management Appeals Unit
          PO Box 80
          Buffalo, NY 14240-0080
Fax: 1-716-887-7913

**Appeal Levels**
There are two kinds of adverse determination appeals—standard and expedited. Appeals are offered at **one level internally**. The member must be notified of all appeal process rights.

**Internal Appeal Process**
The initial appeal process is an appeal of an adverse determination, whether standard or expedited. The determination of an appeal on a clinical matter will be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination and who are not subordinates of the individual who made the initial determination. The health care professional shall either:
(i) have appropriate training and experience in the field of medicine involved in the appeal, or
(ii) consult with one or more health care professionals who have appropriate training and experience in such medical field.

If a panel of practitioners is utilized in reviewing an appeal, the panel must include at least one practitioner from the same or similar specialty as that which typically manages the medical condition, procedure or treatment.

**Standard Appeal**
Deadline for Requesting an Appeal
Requests for an appeal of an adverse determination may be made by telephone or in writing within 180 days after the member receives notification of the adverse determination. In the event that the member's claim involves Urgent Care, the expedited appeals process would be implemented. Otherwise the standard appeals process is to be used.

Procedure for conducting a standard appeal:
1. Once an appeal is received, pertinent medical records will be requested from the provider (if not already submitted).
2. Written acknowledgment of BlueCross BlueShield's receipt of the appeal request will be sent to the party requesting the appeal 15 days of filing the appeal.
3. If information is necessary to conduct a standard appeal, the member and the member's health care provider are to be notified, in writing, within 15 days of receipt of the appeal, to identify and request the necessary information.
4. If only some of the requested information is provided, BlueCross BlueShield will make a second request for the missing information in writing, within five business days of receiving the incomplete information.

Time Frame Compliance
A decision will be rendered no later than 30 calendar days of receipt of appeal request for pre-service appeals and 60 calendar days of receipt of appeal request for post-service appeals. Written notice to enrollee, the enrollee’s designee, and provider will be sent within two business days of the appeal decision.

Files
BlueCross BlueShield maintains files on all appeal requests and decisions.

Expedited Appeal
Eligibility for Expedited Appeal process is available to members appealing adverse determinations involving:

- Continued or extended health care services
- Procedures, treatments, or additional services for a member undergoing a course of continued treatment prescribed by a health care provider
- Situations in which a health care provider believes an immediate appeal is warranted, except post service adverse determinations
- Any situation that would increase risk to the member's health
- Denial for home health care services following a discharge from a hospital admission

If BlueCross BlueShield requires information necessary to conduct an expedited appeal, BlueCross BlueShield shall immediately notify the member and the member’s health care provider by telephone or facsimile to identify and request the necessary information followed by written notification.

The clinical peer reviewer will be available within one business day, or sooner.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process.

Time frame Compliance for Expedited Appeal
A decision will be rendered no later than two business days or 72 hours, whichever is less, after receipt of appeal request. Immediate notification of the decision will be given by telephone, followed by written notice, which will be sent within 24 hours of the appeal decision, but not to exceed two business days or 72 hours, whichever is less. Failure to comply with time frames for an internal appeal of a utilization review determination is deemed a reversal of the initial determination.

Full and Fair Review Process:
This is for all lines of business except Medicare Advantage and ASO that are grandfathered per HR3590H.R. Patient Protection and Affordable Care Act (PPACA).
The purpose is to provide the claimant with all the new or additional evidence that the plan considers, relies upon, or generates in connection with an appeal that was not available when the initial adverse determination was made.

The claimant will be provided any and all additional information submitted during their appeal process which resulted in a final adverse determination (FAD).

Final Adverse Determination of an Internal Appeal Process

Each final adverse determination of an Appeal is sent to the member or their designated representative and provider, and must include the following information:

1. A clear statement describing the basis and the specific, scientific, or clinical rationale for the denial and instructions for requesting the clinical review criteria used.
2. Reference to the evidence or documentation used as a basis for the decision, including whether any internal rule, guideline, protocol or similar criterion was relied upon in making the determination. In cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used.
3. The provisions of the policy, contract or plan on which the determination is based.
4. A clear statement that the notice is the final adverse determination.
5. The health care plan's contact person and his/her telephone number.
6. The member's coverage type.
7. The name and full address of the health care plan's utilization review agent.
8. The utilization review agent's contact person and his/her telephone number (for example the manager/responsible for the utilization review agent).
9. A description of the health service that was denied, including, where applicable and available, the name of the facility and/or physician proposed to provide the treatment, and/or the developer/manufacturer of the health care service.
10. A statement that the member may be eligible for an external appeal and the time frames for requesting the appeal.
11. A statement that the member is entitled to receive, upon request and free of charge:
   - Reasonable access to and copies of all documents, records, and other information relevant to the claim.
   - A copy of each internal rule, guideline, protocol or similar criterion that was relied upon in making the determination on appeal.
   - A list of titles and qualifications (including specialist of individuals participating in the appeal review).
12. The information supplied by the Superintendent of the New York State Department of Financial Services (NYSDFS) describing the external appeal process.
13. A statement that the claimant may have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

BlueCross BlueShield will maintain files on all appeal requests and decisions made. A member must receive standard appeal rights with the expedited internal appeal decision.
New York State (NYS) External Appeal
A member has the right to an external appeal of certain coverage determinations made by BlueCross BlueShield or our vendors. An external appeal is a request by a member to the New York State Department of Financial Services (NYSDFS) for an independent review by a third party known as an external review agent. External review agents are certified by New York State and may not have a prohibited affiliation with any health insurer, HMO, medical facility, health care provider, or member associated with an appeal.

The determination of the external review agent is binding for both the member and BlueCross BlueShield.

Eligibility for a NYS External Appeal
A member cannot request an external appeal unless we have issued a final adverse determination of an Internal Appeal Process. However, if BlueCross BlueShield disagrees with the admission of a provision or continuation of care by a facility for an enrollee diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified by the member's attending health care practitioner), BlueCross BlueShield shall initiate an expedited external appeal. Until a decision is rendered, the admission of, provision of, or continuation of care for the enrollee by the facility shall not be denied and BlueCross BlueShield shall provide continued coverage. If BlueCross BlueShield does not initiate an expedited external appeal, then BlueCross BlueShield shall reimburse that facility for services provided.

An expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment. BlueCross BlueShield must include an application for an external appeal in the Final Appeal Determinations (FAD) to the member for all denials. Providers may obtain an application on the NYS Department of Financial Services website.

To be eligible for a NYS external appeal, the final adverse determination must be made on the basis that the service is not medically necessary, or the requested service is experimental or investigational, not materially different (out-of-network service request), training and experience (out-of-network referral request) or treatment of rare disease, as explained below;

1. Medical Necessity
The service or treatment is denied, in whole or in part, on the grounds that the service or treatment is not medically necessary and the service would otherwise be covered under the member's contract.

2. Experimental or Investigational
a. The service or treatment is denied on the basis that it is experimental or investigational; and
b. The member's attending practitioner has certified that the member has a life-threatening or disabling condition or disease (i) for which standard treatment or services have been ineffectual or would be medically inappropriate, or (ii) for which
there does not exist a more beneficial, standard service or treatment that is covered, or (iii) for which there exists a clinical trial; and

c. The member's attending practitioner (who must be a licensed, 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 (i) a health service or treatment or procedure including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B) that, based on at least two documents from the medical or scientific evidence, is likely to be more beneficial to the member than any covered, standard service or treatment; or (ii) a clinical trial for which the member is eligible. Any physician certification shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation; and

d. The service or treatment would otherwise be covered except for the determination that it is experimental or investigational.

3. Out-of-Network Denials
There are two types of out-of-network denials that are eligible for external appeal:

- Out-of-network service denial. The member’s preauthorization request was denied because, while the service is not available in-network, the health plan recommends an alternate in-network service that it believes is not materially different from the out-of-network service.
- Out-of-network referral denial. The member’s out-of-network referral request was denied because the health plan has an in-network provider with the appropriate training and experience to meet the particular health care needs of the member.

4. Rare Disease
An enrollee with a life threatening condition who may require “rare disease treatment” may seek an external review for an adverse determination. Treatments of “rare diseases” would be approved, upon external review, if they contain all of the following;

- A physician certification and evidence presented by the insured or the insured’s physician
- The treatment for the rare disease would be “likely to benefit” the enrollee, and
- The benefit of such treatment outweighs the risk of said service or procedure.

Agreeing to a NYS External Appeal
BlueCross BlueShield members can request an external appeal even though we have not completed the initial appeal process. We are under no obligation to agree to this request. The Manager of Utilization Management Appeals, in conjunction with the Medical Director, considers all requests for waiving the initial appeal process on an individual basis.

If BlueCross BlueShield agrees to waive the internal process, BlueCross BlueShield must provide a written letter with information regarding filing an external appeal to member within 24 hours of the agreement to waive the BlueCross BlueShield internal appeal process.
NYS External Appeal Procedure
Members or their designees must send an external appeal application to the Department of Financial Services within four months from the date of the final adverse determination OR the waiver of the internal appeal process. Providers appealing a concurrent or retrospective adverse determination on their own behalf must request an external appeal within 60 days of the final adverse determination. If you do not send your application to the Department of Financial Services within the required timeframe (with an additional eight days allowed for mailing), you will not be eligible for an external appeal.

If a member files an external appeal, the member's claim will be reviewed by an External Appeal Agent whose decision will be binding on BlueCross BlueShield and the member.

Providers have their own right to an external appeal when health care services are denied concurrently or retrospectively, and must request an external appeal within 60 days.

For provider requested external appeals of concurrent adverse determinations: the provider is responsible for the cost if the external appeal is upheld, and both the provider and the plan are responsible for this cost (evenly divided) if the external appeal is upheld in part (partial overturn).

Administrative Services Only (ASO) External Appeal Process
The plan will provide notice of external appeal rights in the notice of the final internal adverse benefit determination. An ASO external appeal request application and an external appeal instruction sheet will be included in the notice. The member/representative has **four months** from the receipt of the final internal adverse benefit determination to request an ASO external appeal.

**Eligibility:** An ASO external appeal is not requested unless we have issued a final adverse determination of an appeal. Following an expedited appeal, the plan cannot require members to use the standard internal appeal process before requesting an external appeal. To be eligible for an ASO external appeal, the final adverse determination must be made on the basis that the service is not medically necessary, or the requested service is experimental / investigational. External appeal rights do not exist for any other determinations, even if those other determinations affect coverage. A member and/or member's representative may request an external appeal.

The determination of the ASO external appeal agent is binding for both the member and the health plan.

Medical Claims Review
Medical Claims Review staff performs medical record reviews for medical appropriateness and adverse determination for the following types of claims routed from Claims Processing:
• outpatient procedures and services
• inpatient level of care
• durable medical equipment
• infusion therapy
• professional claims for inpatient and outpatient services
• all services where medical necessity determinations are to be made

The reviews are performed by health care professionals and administrative personnel, who determine:
• contract eligibility, such as cosmetic procedures
• medical appropriateness of services rendered
• whether provider and member education is needed, which will generate a referral to the appropriate department

Timeframes for Processing Medical Claims/Post Service Claims

Complete Claims: BlueCross BlueShield will render a decision (approval or denial) and provide written notice to the member or their authorized representative within 30 calendar days after receipt of the claim.

Incomplete Claims:
If BlueCross BlueShield is unable to make a decision due to failure to submit all necessary information, we may afford an extension of time to submit the missing information. If we allow the extension, we must provide notice within 30 calendar days after receipt of the claim of the specific missing information. We must allow 45 calendar days from the date of our notice to submit the missing information.

If we receive any of the information requested, we will render a decision and provide notice in writing within 15 calendar days after receipt of the information. If no information is submitted within the 45 calendar days, we must render a decision and provide notice within 15 calendar days after the end of the 45 day period.

New York State Prompt Pay Legislation requires that:
• Decisions on claims for which adverse determinations are made are sent to the provider or member submitting the claim within 30 calendar days of claim receipt.
• Claims submitted electronically must be paid within 30 days and paper or facsimile claim submissions must be paid within 45 days.
• If medical records are to be requested, the request will be made within 30 calendar days of claim receipt.
• The clock is reset to meet the above timeframes once medical records have been received.
• A financial penalty is applied if claims are not processed within the above time frames.
**Member Clinical Quality Complaints**
To assess member experience with services, all member clinical complaints, and clinical complaint appeals, including behavioral health care, that involve quality of care/service, attitude, access to care, and quality of practitioner office site, are referred to the Utilization Management Quality Specialist (UMQS) for review investigation and/or resolution.

- Complete investigation of the substance of the complaint including specific aspects of the clinical care involved is documented in a clinical management software tool. Pertinent medical records and practitioner/provider responses necessary to the investigation are included. Medical record documentation is reviewed with the Medical Director to reach a complaint determination of substantiated or not substantiated.
- The member has a right to file a Level II Appeal if they do not agree with the initial determination of their initial complaint.

The identification and tracking of these clinical complaints are used for reporting and evidence necessary for internal and external auditors and regulatory requests.

**Accreditation and Regulatory Compliance Unit**

The purpose is to ensure that regulatory compliance for Utilization Management activities is adhered to both internally and with our delegated vendors.

**Internal Compliance Oversight**
Internal Utilization Management policies and procedures related to regulatory compliance issues are developed and updated at least on an annual basis or more frequently as warranted by new legislation standards. Oversight of letter development and updates to letters are a responsibility of this unit. Tools are developed for medical record review to incorporate all aspects of regulatory compliance activities. Medical records are audited on a regular basis to ensure compliance.

**External Vendor Compliance Oversight**
Our delegated vendors for Utilization Management activities are monitored through on-site visits by members of Utilization Management, Vendor Process Management, and others, as applicable. During the on-site review, the vendor’s plan, policies and procedures, and UM activities are reviewed to ensure compliance with Article 49 of the NYS Health Law, CMS regulations, Federal Department of Labor (DOL), and NCQA standards. Medical necessity criteria are reviewed and approved by the Medical Management Clinical Committee (MMCC), or an ad hoc group of physician specialists, and the plan’s Medical Director. Medical records are audited at least quarterly and more frequently if any deficiencies are noted. Vendor self-audits and more frequent medical record audits are conducted if necessary.
Utilization Data Tracking and Analysis
Utilization tracking is provided for the organization as a whole for all lines of business. The focus is:

- Appropriate delivery of health care services to our members
- Overall utilization tracking
- Use of services (HEDIS)
- Monitoring of services

Generally, both forms of data tracking involve the following activities:

- Establish a baseline of medical care delivered to our members
- Establishing historical utilization patterns for benchmarking purposes
- Determining the level of statistical significance
- Designing and implementing data-collection methodologies
- Trend analysis
- Compiling data into tables and graphs for easy reference
- Determining a need for interventions
- Analysis of implemented interventions
- National benchmarks
- Utilizing all available information technology

Focused Monitoring
The purpose of focused monitoring is to track the patient's outcome, frequencies of specific services and costs. Generally, these services either have a high potential for abuse or need to be followed to assess:

- Medical appropriateness
- Monitoring services specific to the individual safety needs and risks in conjunction with co-morbidity issues
- Potential barriers to care
- Potential under or over utilization by practice, and by product line
- The utilization impact of pricing, benefit or other administrative changes

Appropriate interventions are implemented as opportunities are identified. The interventions are measured for effectiveness and the impact on the quality of care.

Overall Utilization Tracking
The purpose of overall utilization tracking is to establish norms that serve as the statistical baseline for determining shifts and trends in overall utilization which detail quality care delivered to our members.

Medical Policy Unit
The Medical Policy Unit researches, analyzes, and recommends Corporate Medical Protocol for all lines of business and effectively communicates each, both internally and externally (refer also to Section 8 – Corporate Medical Protocols).

Corporate Medical Protocol Development
BlueCross BlueShield will develop and monitor corporate medical policy, to evaluate the inclusion of new technologies and the new application of existing technologies. This
includes medical and behavioral health procedures and devices. (Pharmaceutical policies are developed by the Clinical Pharmacy Services Unit; vaccine recommendations are provided in the Practice Guidelines; refer to Section 9 - Pharmacy and Section 11 - Practice Guidelines.) A decision to develop or revise Corporate Medical Protocol is made based on one or more of the following:

- New technology/procedure/vaccine/device becomes available
- A new application/indication is noted in literature for existing technology, procedure, vaccine, or device
- Physician request
- Annual review

Assessment criteria utilized for evaluating new technology and/or a new application to existing technology is contained in our Technology Assessment Protocol (refer to Medical Protocols on the provider website).
Section 6 – How to Obtain Utilization Management (UM) Preauthorization

Please refer to the Stat Bulletins, Clinical Protocols, and Code & Comment (found on our website) and contacting Provider Service with questions for additional information and detail as to whether a procedure requires preauthorization.

To obtain preauthorization for medical/surgical procedures:

Please fax your request* along with supporting clinical documentation such as, but not limited to: history and physical, office notes, radiology studies, medical testing, and conservative treatments/therapy notes to our Utilization Management Department at (716) 887-7913. Please include the following information:

• Member’s name, date of birth and ID number
• Diagnosis code(s)
• Current Procedural Terminology (CPT) code and /or Healthcare Common Procedure Coding System (HCPCS) code
• Date of service
• Facility name
• Requesting MD name and address
• Tax ID number
• Office phone number
• Office fax number
• Office contact

*UM forms are available on our Provider website. Go to: Tools & Resources > Forms > PATIENT CARE FORMS bcbswny.com/content/WNYprovider/tools-resources/forms.html

Durable Medical Equipment/Prosthetics/Orthotics

BlueCross BlueShield will pay for basic, standard durable medical equipment (DME) which has been determined to be medically necessary. **Coverage is dependent upon member contract exclusions and benefit limitations.** We will determine whether the item should be purchased or rented.

Durable medical equipment is equipment which is intended for repeated use, and is primarily and customarily used to serve a medical purpose. These items are generally not useful to a person in the absence of disease, illness or injury, and are appropriate for use in the patient’s home.

We follow the Centers for Medicare & Medicaid Services (CMS) billing guidelines for upgraded DME items. The member has no financial liability for the cost of an upgraded item or components unless he or she makes an informed decision by signing a financial
liability form (for Medicare Advantage members, this form is the Advance Beneficiary Notice of Non-coverage (ABN)). An upgrade refers to a piece of equipment that is medically unnecessary because it exceeds the member’s medical needs or has a medically unnecessary component that is in excess of medical needs (e.g., deluxe model or deluxe features). This process cannot be used as a way to cover increased costs (e.g., batteries for a wheelchair that have been provided with no additional charge to the member cannot be labeled as an upgrade in order to receive additional money because the cost of the wheelchair has increased).

- Specific durable medical equipment, as defined by the Utilization Management Department, is subject to the preauthorization process unless determined to be exempt from this process. Please refer to Code & Comment.
- Utilization Management reviews requests for durable medical equipment to determine if all of the requirements as listed are satisfied:
  - Equipment is prescribed by a practitioner within the scope of his/her license.
  - DME equipment must be medically necessary and meet criteria.
  - No coverage is available for equipment that BlueCross BlueShield has determined is not reasonable. When a claim is filed for equipment containing features of an athletic nature, features of a medical nature that are not required by the patient's condition or deluxe features when standard equipment meets the member's needs, the amount payable is based on the allowance for the equipment without the added features.

**Preauthorization Exempt Codes**

- BlueCross BlueShield requires that preauthorization be obtained for coverage of certain DME and certain prosthetics/orthotics. Updates to this listing will be communicated via Stat Bulletins. Please refer to Code & Comment.

**DME Rental Policy**

When a DME provider's assets are purchased by another provider, the policy for the rental of a capped DME item for our members receiving these services is as follows:

- If the change occurs during an active phase of equipment rental, the previous rental months are counted. We will continue monthly rental payments to the new DME provider until the capped rental is met, at that point, the item is considered owned by the member.
- The new purchasing provider may not start a new rental cycle period at the time of acquisition of the previous provider’s assets. It is the same piece of equipment for the same patient. Equipment rental is based on the member's benefits regardless of who is providing the service.

**Repairs and Replacement Parts**

We utilize CMS guidelines when considering repair and/or part replacement of DME for reimbursement. Key provisions include:
1. The item must be owned by the member and no longer covered under warranty
2. No reimbursement will be made if the repair expense exceeds the expense of purchasing a replacement
3. A valid HCPCS code specifically describing the replacement part must be used, if available. If there is not a valid HCPCS code, use the modifier RB with the code that best describes the piece of equipment
4. Invoices for replacement parts must be included with your claim

All DME, prosthetic and orthotic items billed to us require a prescription. The prescription must be signed and dated by a qualified provider.
Section 7 – Case and Disease Management Services

A variety of clinically based programs are in place for addressing the needs of members across the continuum of care, including multiple health management programs to address the needs of members with complex health care needs, those with physical or developmental disabilities, multiple chronic conditions and severe mental illness. These programs are designed to meet the care needs of the member population through identification, participation, engagement, and targeted interventions aimed at active engagement in health care services. The goal is to maintain or improve the physical and psychosocial well-being of individuals to address health disparities through cost-effective and tailored health solutions.

Case Management Services

The case management program assumes responsibility for the coordination of care for members identified with complex or high-risk conditions. This program is aimed at improving the health of the member population across the continuum of care. The role of the case manager is to promote quality care and meet the member’s needs while maximizing benefits and assuring proper use of services in the most appropriate setting.

Who is eligible and how are members identified for the program?
All members actively enrolled in the plan are eligible for case management services. Members can be identified for services through:
- Health Information Line referral
- Predictive modeling reporting
- Outpatient medical claims/inpatient hospital claims
- Pharmacy claims
- Provider referrals
- Member or care giver self-referral
- Staff referrals (including Utilization Management and on-site nurse referrals)

Are there different types of Case Management Services?
Yes, there are several different types of case management. It ranges from general needs of members with multiple comorbidities to highly specialized, disease-specific case management.

The different categories of case management we address are:
- Behavioral Health/Substance Use Disorder
- Chronic Kidney Disease
- Complex for high risk members with multiple comorbid conditions
- Spine
- Hip and Knee
- HIV/AIDS
- Maternal-Child for high risk pregnancy (Right Start program)
- Oncology
- Palliative Care
• Transplant (transplants such as heart, lung, kidney, pancreas, or bone marrow)

What services are offered to our members who enroll?
• A member-focused care plan developed using their provider’s direction
• One-on-one intervention, on the telephone, from a case manager to the member, including education on disease state(s), care plan development, care coordination, and additional resources for information
• Regularly scheduled telephone communication that allows the member to be monitored at home and assists members with condition self-monitoring
• An interdisciplinary team approach including nurses, social workers, dietitians, and pharmacists to interact with members
• Ongoing assessment to determine level of support available to the member
• A single, direct contact for member when issues arise
• Coordination of services with the primary care provider or specialist, as indicated to achieve successful care transitions
• Direction to local and community services, when applicable
• Direction to health education providers to maximize their benefit and support adherence to treatment plan
• Address any social determinants of health impacting members’ health, functioning and quality of life outcome and risks

Behavioral Health Case Management Program
The fundamental focus of the Behavioral Health Case Management program is to identify members at highest risk of poor health outcomes, including members with mental health and substance use disorders such as first episode psychosis, mood disorders, attention deficit disorders, autism, and opioid dependence. Behavioral Health Case Managers use a person-centered approach, developing personalized plans, and providing appropriate access to covered services.

This integrated care approach focuses on health literacy, utilization of community supports and resources to assist members in navigating the health care system and comprehensive care coordination. This infrastructure will help to provide members access to the care they may need in a timely manner while enabling increased quality and better health outcomes.

A behavioral health case manager will use referrals, risk stratification, hospital discharge notifications, and emergency room visits to identify members eligible for the program. Collaboration between contracted providers and behavioral health case management staff is necessary and is an expected condition of provider participation.

Additional Resources:
To obtain additional information about our Case Management program, please contact us at 1-877-878-8785, option 2.

Disease Management Services

Our Disease Management Programs are population-based, risk-stratified, goal and outcome oriented programs that aim to align the member, caregiver, provider delivery
system and planned interventions to improve the health of members. Disease Management has established an integrated model with the focus on meeting the needs of members with chronic conditions through care management services, member education, empowerment and support.

Disease Management Program interventions have been implemented to assist members in understanding their disease, promotion of self-management skills and development of a collaborative relationship with the providers to help decrease complications while also managing health care costs. The Disease Management team consists of nurses, dietician/certified diabetes educators, social workers, respiratory therapist, and outreach workers to assist members.

Who is eligible and how are members identified for the program?
- All members actively enrolled in a plan with a disease management diagnosis are eligible for disease management services.

Members can be identified for services through:
- Health Information Line referrals
- Member or care giver self-referral
- Predictive modeling reports
- Outpatient medical claims/inpatient hospital claims
- Pharmacy claims
- Provider referral
- Staff referrals (including Utilization Management and on-site nurse referrals)

Are there different types of Disease Management Services?
Yes, we offer disease management programs for the following conditions:
- Asthma
- Attention-deficit hyperactivity disorder (ADHD)
- Cardiac Management, includes Coronary Artery Disease (CAD) and Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Hip and Knee
- Holistic Health
- Obstructive Sleep Apnea
- Spine Health Management
- Stroke Management
- Substance Use Disorder

What services are offered to our members who enroll?
- Support and health care guidance for members with chronic illnesses
- A member-focused educational plan is developed using evidence based guidelines
• One-on-one intervention, via telephone, from disease care manager to the member, including education on disease state(s), care plan, and resources for information
• If needed, follow-up scheduled telephone communication that allows the member to be monitored in his/her home
• A single, direct contact for the member when issues arise, a registered nurse is assigned to the member for the duration of his/her health care needs
• Direction to local and community services, when applicable
• Direction to health education providers to maximize their benefit and support adherence to treatment plan

Additional Resources:
To obtain additional information about our Disease Management program, please contact us at 1-877-878-8785, option 2.

Our Commitment to Practitioner Rights
1. You have the right to request information about our services, staff qualifications, and any contractual relationships.
2. You have the right to work with or decline to participate in our patient programs and services.
3. You have the right to be informed how we coordinate interventions with treatment plans for individual patients.
4. You have the right to know how to contact the person responsible for managing and communicating with your patients.
5. You have the right to be supported by us when interacting with patients to make decisions about their health care.
6. You have the right to receive courteous and respectful treatment from our staff.
7. You have the right to communicate complaints, or other feedback to us by calling Provider Service at 1-800-471-4685.
Section 8 – Corporate Medical Protocols

BlueCross BlueShield publishes Corporate Medical Protocols to give participating providers a concise overview of medical necessity criteria utilized to determine coverage of services rendered. The Corporate Medical Protocols also identify and explain services that are investigational or experimental. BlueCross BlueShield reviews and re-evaluates the Corporate Medical Protocols at least annually and more frequently as new information emerges that affects them. A cover letter describing the changes to the Corporate Medical Protocols is published 30 days in advance of their effective date. The effective date is included in our quarterly provider newsletter, Network News and Updates.

Development of the content included in the Corporate Medical Protocols is discussed in Section 5 under Medical Policy Unit. Updated protocols and cover letters are available to providers on our website.

The Corporate Medical Protocols provide clinically significant information about medical treatment that, if not adhered to, may affect the payment a provider receives. When a service is denied because it does not meet the medical necessity criteria contained within the protocol or the preauthorization requirement is not adhered to, the member is held harmless and cannot be billed. Payment for covered services is always subject to individual contract limitation and member eligibility at the time the services are rendered.


Medical Policy Change Request Process

BlueCross BlueShield provides an established process for participating providers who disagree with our current position regarding a specific medical treatment or technology. The medical policy review process is designed to eliminate undue influence resulting in an unbiased determination. Reconsideration of our corporate position will be made if/when published, peer-reviewed scientific literature supporting its efficacy becomes available.

A guide to making medical policy change requests can be found on our secure provider website.
Section 9 - Pharmacy

BlueCross BlueShield offers various riders to our members that cover prescription drugs. Benefits and co-payments may vary depending on the rider. Some contracts provide prescription drug coverage as a basic benefit.

The following will provide you with a general overview of the pharmacy benefits afforded to our members and programs that are in place to manage the benefit. These benefits may vary by plan.

Outpatient Managed Care Drug Benefits

BlueCross BlueShield offers both a Closed and a Three-Tier Managed Prescription Drug Benefit to members. Drugs administered or dispensed while the member is a patient in a hospital, nursing home, doctor's office, outpatient clinic or other institution are not covered under this benefit. The member, however, may be entitled to benefits under their basic medical contract.

With the Closed/Managed Formulary Benefit, physicians may prescribe drugs included on the BlueCross BlueShield Drug Formulary. The Formulary promotes the safe and effective use of drug therapies by helping physicians select the drug product(s) considered most beneficial to their patient populations. BlueCross BlueShield promotes rational, scientific prescribing based upon consideration of published clinical studies, data from the United States Food and Drug Administration (U.S. FDA), community standards, and cost/benefit evaluation.

The Formulary contains a list of approved and preferred medications. It was developed and is maintained under the direction of our Pharmacy and Therapeutics (P&T) Committee. This committee consists of local physicians, community and health-system pharmacists, and other appropriate professional staff.

The goal of the Formulary is to improve the value of pharmaceutical care delivered through proper consideration of both quality-of-care and economic issues.

The P&T Committee evaluates, appraises, and selects those drugs considered to have the highest contribution to patient care from among the numerous pharmaceutical products available. Through a continuous improvement process, the P&T Committee performs therapeutic drug class and product specific evaluations to make recommendations that will allow us to maintain a clinically appropriate, cost-effective formulary. Criteria such as efficacy, safety, risk/benefit ratio, therapeutic outcome and cost are all included in the assessment process. BlueCross BlueShield providers are strongly encouraged to reference the Formulary before authorizing prescriptions. For the latest pharmacy information, providers and members may visit bcbswny.com.

At the point of dispensing, the pharmacy will receive a message each time a non-formulary medication is being filled. If you prescribe a non-formulary medication, the pharmacist may contact you prior to dispensing to discuss formulary alternatives.
Please consider the appropriateness of formulary treatment options for each patient. Many times a therapeutic switch can be made that will offer the patient the same outcomes to which they are accustomed.

The Three-Tier Drug Benefit provides greater drug selection by making both Formulary and Non-formulary medications available. These medications are divided into three tiers, with a copayment or coinsurance associated with each tier as follows:

- **First Tier**: If a medication is a generic Formulary agent, this medication is listed in the first tier, with the lowest copay applied. As an exception, very inexpensive branded Over-The-Counter (OTC) agents may be placed on the first tier.
- **Second Tier**: Preferred brand agents are placed in the second tier, having the middle copay.
- **Third Tier**: If a brand name or generic medication is not on the BlueCross BlueShield Formulary, it will be listed in the third tier, with the highest copay applied. This would include brand name medications for which there are generics available, non-preferred brand agents and excessively priced generic agents.

**Benefit Limitations**
Both the Closed Formulary and the Three-Tier Drug Benefit have the following limitations:

**Day Supply Limitation**
In general, we will pay for up to a 30 calendar day supply of medication each time a prescription is filled or refilled at a retail pharmacy. We will cover up to a 90 calendar day supply of medication at a mail order pharmacy. Day supply limits may vary by benefit plan and by medication.

**Refill Limitations**
For chronic medications, we will pay for refills up to one year after the prescription was originally issued if so authorized by the prescriber. Applicable state medication dispensing laws may limit this allowance for federally scheduled medications, i.e., controlled substances.

**Smoking Cessation**
BlueCross BlueShield of Western New York members with preventive coverage have a pharmacy benefit to allow access to smoking cessation agents, both prescription and over-the-counter products. Cost of the products will be determined by the member's assigned co-pay.

**Step Therapy**
More cost-effective drugs should be prescribed whenever therapeutically feasible. In particular, step therapy is encouraged for classes of medication that contain multiple agents with similar effectiveness. For example: intranasal steroids, migraine treatment, and urinary agents.
Exclusions
Certain medications may be excluded from coverage under a member’s benefit plan. In most cases, if a member attempts to fill a prescription for an excluded drug, they will have to pay the full retail price. Below is a sample list of drug exclusions:

- drugs that are generally administered by a health care professional
- products not approved by the U.S. Food and Drug Administration as a prescription drug
- vitamins, with the exception of pre-natal and fluoride-containing vitamins
- drugs prescribed for cosmetic use
- prescription drugs when the product is available over-the-counter in the same strength and dosage form
- allergy extracts and vaccines

Please note that exclusions may vary by benefit plan. This list is not all encompassing and does not apply to all benefit plans.

Preauthorization Request Process
Our prescription drug and medical injectable policies promote safe and effective use by helping physicians select the drug product(s) considered most beneficial to their patients. In order to ensure thorough consideration of both quality-of-care and economic issues, some drugs require prior authorization to be covered under a member’s prescription drug or medical benefit. We work with a committee of local physicians, mid-level practitioners, and pharmacists to identify medications that should require prior authorization and to develop the medical criteria used to determine when coverage for these agents is appropriate.

Preauthorization will be based on specific medical criteria including dosage and the patient's condition. If preauthorization is not obtained, payment of the claim for the prescription will be rejected at the time the prescription is filled. The pharmacy will be notified through the on-line prescription claims processing system to contact the prescribing physician and advise him or her to obtain preauthorization.

Medications for medically assisted treatments (MAT) for opioid addiction do not require preauthorization when prescribed by an appropriately licensed or certified provider or clinic. Some medications administered under the medical benefit, such as injectables or implants, may require preauthorization.

Note: The preauthorization requirements must be followed for all managed care members. Physicians must request preauthorization by faxing the Preauthorization/Non-Formulary Request Form to the number on the form. If a fax machine is not accessible, call our customer service department.

If you need a Preauthorization/Non-Formulary Request Form, log on to our secure provider website to access the Medication Guide and Preauthorization/Non-Formulary Request Form, or contact Provider Service.
Non-Formulary Request Process

For members that have a Closed Formulary Benefit, coverage of formulary products may be available. If in the provider's professional judgment a non-formulary (3rd tier) agent is necessary, he/she must submit a non-formulary medication request form along with any supporting documentation to BlueCross BlueShield.

All requests for use of prior-authorization/non-formulary agents will be reviewed in a timely manner per New York State regulations and notification will be returned via fax, phone or mail.

To expedite the review process, please be sure to complete all information requested on the form.

- Be sure that the writing is legible. Faxed copies are often more difficult to read.
- Patient name, identification number and date of birth should always be included.
- A complete list of medications previously tried by the patient, including samples dispensed from the provider's office, is required to accurately evaluate the request. Specific dosages prescribed, dates of service and/or reasons for discontinuation (i.e., ineffective, adverse reactions, unacceptable side effects) should also be provided.
- If preauthorization / non-formulary criteria requires laboratory results, submit a copy of the lab report or document this information on your request.
- Clearly note if the patient has any medical conditions or is taking other medications which limit the use of alternate formulary agents.
- If insufficient information is provided, the request will be pended or denied and returned to you for additional information.

Drug Therapy Guidelines

Drug Therapy Guidelines are developed and updated under the direction of our P&T Committee. These guidelines are used to support coverage determinations for preauthorization requests. Notifications are routinely faxed to BlueCross BlueShield providers to help ensure medications are prescribed appropriately and in the most cost-effective manner. In each quarterly update, providers are directed to the guidelines published on our website. Participating providers are required to follow these guidelines when prescribing medications.

Outpatient Traditional Drug Benefits

BlueCross BlueShield offers various prescription drug riders to our members who have traditional/indemnity coverage. Benefits and co-payments vary depending upon the rider. Detailed information about prescription drug riders is included in the member's contract. Drugs administered or dispensed while the member is a patient in a hospital, nursing home, doctor's office, outpatient clinic or other institution are not covered under this benefit. The member, however, may be entitled to benefits under their basic medical contract.
We encourage you to refer to the BlueCross BlueShield Drug Medication Guide and Drug Therapy Guidelines for all members, including those who have traditional/indemnity coverage. Please visit our website at bcbswny.com/provider for the most current Drug Formulary and Drug Therapy Guidelines.

Express Scripts®

Prescription drug benefits for BlueCross BlueShield of Western New York members are managed by Express Scripts, America's leading prescription drug benefit manager.

The Benefits of Express Scripts for our Members
Express Scripts offers a variety of services to our members, including:
• Members may choose any pharmacy in the retail pharmacy network.
• 24 hour customer service, 7 days a week (except Thanksgiving and Christmas)
• 24 hour pharmacist support

Mail Order
Using Express Scripts® mail order pharmacy, members can obtain up to a 90-day supply of medication, usually for a lower copayment than for comparable retail prescriptions.
• Members will ask for a new prescription for up to a 90-day supply, plus refills for up to one year (if appropriate).
• The member will mail the new prescription using an Express Scripts mail order form and envelope supplied by Express Scripts.
If necessary, members may ask for a second prescription for a 14-day supply to cover the time period between the request for mail order and its fulfillment. Please note that some medications are not eligible to be filled for a 90 day supply.
Section 10 - Health Care Quality Improvement

Mission Statement

The Plan recognizes the need for a comprehensive and culturally sensitive Health Care Quality Improvement Program. The Program is initiated and carried out in a manner designed to meet the goals and objectives of the corporation and all regulatory requirements.

Program Goal Statement

The focus of the program is to continuously assess and improve the care delivered by our participating practitioners/providers and the service delivered by the plan staff to its members. The organization has the responsibility of designing, measuring, assessing and continually improving its performance. The result is enhanced health and well-being of the populations we serve.

Program Objectives

- Assist in the corporate mission and vision
- Integrate quality improvement activities into corporate strategic plans and goals
- Initiate and monitor activities to identify quality/safety of care, access and service issues
- Identify best practices through review of structure, processes, outcomes and benchmarks
- Report quality assessment information and make recommendations regarding participation of practitioners/providers according to the approved credentialing process
- Develop, implement, and evaluate interventions to improve the quality and safety of care and services
- Distribute quality improvement activity findings as part of a Quality Improvement Process (QIP) or Problem Solving Process (PSP)
- Sponsor and support interdepartmental quality improvement activities (including QIP/CCIPs for case management and action plans for improved member service)
- Promote a high standard of care through analysis of clinical practices
- Adopt national (or regional, if more stringent) standards, criteria and benchmarks for health care quality improvement activities
- Serve as a resource to practitioners/providers, supplying consultation and education relating to implementation of the quality improvement programs
- Provide a leadership role in health improvement programs, utilizing clinical and preventive care guidelines, best practice, and clinical quality measures
- Educate practitioners/providers and members toward improving health and health care
- Meet and exceed all requirements for regulatory and accreditation oversight (CMS, NYSDOH/DFS, NCQA, and BCBSA)
• Identify areas of the health care provided to our members that require improvement and take corrective action

Scope
The scope of the Health Care Quality Improvement Program is comprehensive. It includes all BlueCross BlueShield members for all operating areas, as well as practitioners and providers who participate in the network. This includes Commercial (HMO, POS, PPO, Federal Employees Program/FEP), EPO, Medicare Advantage, ASO, Essential Plan and Exchange/Qualified Health Plan products and oversight of Child Health Plus and Medicaid managed care. The Health Care Quality Improvement Program includes organization-wide activities, a focus on trend analysis, and development of interventions that improve the quality of care and service provided to members. The activities include clinical, service, and patient experience.

The Health Care Quality Improvement Program monitors and evaluates a wide variety of clinical and service topics that include, but are not limited to, those listed below:

- Health Promotion
- Preventive Care
- Disease Management
- Case Management-coordination of care
- Population Health Management
- 24 hour health information line
- Utilization Management (including appropriate utilization of services)
- Patient Safety
- Behavioral Health Management
- Culturally and Linguistically Appropriate Services
- Complaint management for access to care or quality of care issues
- Medical policy
- Pharmacy Management
- Continuity and Coordination of Care
- Accurate and timely phone responses
- Access to practitioners and providers
- Satisfaction/dissatisfaction issues identified through satisfaction surveys, complaints, appeals and grievances
- Information regarding processes, such as competence of staff, attitude of representatives, times of operation, efficiency of program (Customer Service Representative Coaching and Monitoring Program)
- The Health Care Quality Improvement Program at HealthNow New York Inc. includes integration of Public Health goals whenever possible
- Member Touch Point Measures for enrollment, claims processing and customer service

Authority
The ultimate accountability for the Health Care Quality Improvement Program rests with the Board of Directors of BlueCross BlueShield through its Health Care Services and Quality Initiatives Committee of the Board.
The authority and responsibilities for administration and implementation of the Health Care Quality Improvement Program are vested in the Senior Vice President and Chief Medical Officer. The Senior Vice President and Chief Medical Officer and Corporate Quality Management Committee regularly submit reports to the Health Care Services and Quality Initiatives Committee of the Board.

QI Committee Structure
In order to assure that the Health Care Quality Improvement Program is implemented appropriately, key critical responsibilities related to a successful Quality Improvement Program are the shared responsibility of a variety of the committees and subcommittees across the organization.

In support of this shared responsibility the committees, subcommittees, ad hoc committees, etc. will analyze health care related data from monitoring activities, software program output and formal studies, as appropriate.

These committees consider a variety of actions in relation to data as well as a number of other activities that are defined in corporate policies.

These committees include Health Care Services and Quality Initiatives Committee, Corporate Quality Management Committee, Corporate Credentialing Committee, Pharmacy and Therapeutics Committee, Quality Rating Oversight Committee, Medical Management Clinical Committees, Vendor Process Management, Regulatory Compliance and a Behavioral Health Advisory Board Committee.

Monitoring and Evaluation
Results are used to compare with other local plans and regional averages, to revise goals and to target areas of improvement.

Healthcare Effectiveness Data and Information Set (HEDIS)
Measures are primarily clinical in nature, collected annually, audited by an approved contracted vendor, and submitted to NCQA, CMS and the BlueCross BlueShield Association.

Consumer Assessment of Health Plan Study (CAHPS) survey provides a measurement of how well the plan/practitioners met members’ expectations.

Quality Assurance Reporting Requirements (QARR) is a set of measures for Commercial HMO, Qualified Health Plans (Marketplace), and Medicaid/Child Health Plus populations based on HEDIS-like data, that are collected annually and sent to the NYSDOH.

Medicare Touchpoint Measures (MTM) reflect non-clinical service issues (accuracy and timeliness of enrollment, claims and inquiries).

Medicare Star Rating is consistent with CMS’ Quality Strategy of optimizing health outcomes by improving quality and transforming the health care system. CMS uses a
Five Star Quality Rating System on a scale of 1 to 5, with 5 stars being the highest score a plan can receive and 1 star being the lowest. CMS publishes star ratings in the fall each year and the five-star rating system provides Medicare beneficiaries and their families a way to compare plan performance and quality.

**Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey** is a measure set comprised of clinical quality measures, including National Committee for Quality Assurance (NCQA), HEDIS and a pharmacy Quality Alliance (PQA) measure. The measure set also includes survey-based measures based on questions from the QHP Enrollee Survey that captures member experience and plan efficiency, affordability and management. The quality ratings Five Star rating scale is similar to Medicare Star Rating.

**Population Health Management Strategy**
A variety of clinically based programs are in place for addressing the needs of members across the continuum of care. These include health management programs to address the needs of members with complex health care needs, those with physical or developmental disabilities, multiple chronic conditions and severe mental illness. These programs are designed to meet the care needs of the member population through identification, participation, engagement, and targeted interventions aimed at active engagements in health care services. The goal is to maintain or improve the physical and psychosocial well-being of individuals to address health disparities through cost-effective and tailored health solutions.

**Delegation**
delegated entities are required to meet specific regulatory standards including NCQA, NYSDOH, URAC, and CMS standards. Delegated entities are evaluated annually and key QI and UM documents are reviewed and approved (program descriptions, policies, work plan and annual evaluations). Joint Oversight Team meetings are conducted to ensure contractual obligations are met, document, and follow up on operational issues, and review and evaluate reports based on performance metrics.

**Annual Evaluation of QI Program**
In order to continuously improve the quality and effectiveness of the Health Care Quality Improvement Program, an annual evaluation of the QI program is written and submitted to the Chief Medical Officer, Quality Management Committee and the Healthcare Services Quality Initiatives Committee of the Board.

**QI Work Plan**
The QI work plan is a working document that reflects ongoing progress on QI activities and updates are noted throughout the year as priorities, needs, and goals of the organization change. A mid-year update is presented to the Quality Management Committee and to the Health Care Services and Quality Initiatives Committee of the Board.
Section 11 - Physician Practice Policies

All Practice Guidelines and Administrative Policies for providers can be viewed in pdf format on our website bcbswny.com.

Behavioral Health Practice Guidelines

Clinical practice guidelines for the treatment of attention deficit hyperactivity disorder (ADHD) and depression promote best practice for diagnosing and managing these conditions. Both guidelines are reviewed and updated annually. The ADHD guideline is based upon the published American Academy of Pediatrics guideline on ADHD. Similarly, the depression guideline is based upon the published recommendations of the American Psychiatric Association.

Practice Guidelines and Standards of Care for HIV

BlueCross BlueShield has adopted the New York State Department of Health AIDS Institute’s guidelines and criteria for medical care of adults, children and adolescents with HIV infection.

For HIV Guidelines go to:

hivguidelines.org

nyhealth.gov/diseases/aids

Confidentiality of HIV-related Information
Each health care provider is required to develop policies and procedures (P & P) to assure confidentiality of HIV-related information.

P& P must include:

- initial and annual in-service education of staff, contractors
- identification of staff allowed access and 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
- protocols to protect persons with or suspected of having HIV infection from discrimination

NYSDOH Requirements for HIV Counseling and Testing, and Care of HIV Positive Individuals

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 can help prevent the spread of the disease through education.
The New York State Department of Health (NYSDOH) has requirements regarding HIV counseling, testing and reporting. Established guidelines help increase HIV testing, ensure entry into care and increase laboratory reporting.

An HIV test is the only way to determine whether someone has HIV. The decision to have an HIV test is voluntary.

All practitioners and providers must comply with the HIV confidentiality provisions of Title 27-F of the New York State Public Health Law.

**Routine HIV Testing in Medical Settings**

HIV testing should 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 one percent.

HIV testing **MUST** be offered to all persons over the age of 13 receiving hospital or primary care services, with limited exceptions noted in the law. The offering must be made to those inpatient persons seeking services in emergency rooms, persons receiving primary care as an outpatient at a clinic, or from a physician, physicians’ assistant, nurse practitioner or midwife.

Health care providers in NYS are encouraged to routinely discuss HIV with their patients, **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.

There are three exceptions to the requirement to offer HIV testing:
- If the individual is being treated for life-threatening emergency;
- If the individual has previously been offered or has previously been tested for HIV (unless otherwise indicated due to more recent risk behavior);
- If the individual has been determined by the attending provider to lack mental capacity to consent.

**HIV RISK CHANGES, TEST REGULARLY**

<table>
<thead>
<tr>
<th>Clinical Indications</th>
<th>Routine Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whenever STI screening is done on a patient who is not known to have HIV</td>
<td>Every 3-5 years for all sexually active individuals</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Every year if the patient or their partner:</td>
</tr>
<tr>
<td>• at the 1st prenatal visit</td>
<td>• is sexually active &amp; has had condomless anal or vaginal sex with a new partner since the patient’s most recent HIV test</td>
</tr>
<tr>
<td>• during the 3rd trimester</td>
<td>• has had any new STI within the last 12 months</td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td>Every 3-6 months if the patient or their partner:</td>
</tr>
<tr>
<td>• TB infection</td>
<td>• is a man who is gay, bi-sexual or has sex with men</td>
</tr>
<tr>
<td>• suspected TB</td>
<td>• injects non-prescription drugs/hormones/cosmetic fillers</td>
</tr>
<tr>
<td>Suspected Acute HIV (AHI) – persistent flu-like symptoms starting 1-4 weeks following a potential HIV exposure</td>
<td>• exchanges sex for money/drugs/housing</td>
</tr>
<tr>
<td></td>
<td>• has a sex partner living with HIV whose viral load is greater than 200 copies/mL³ or not known.</td>
</tr>
</tbody>
</table>

For patients on PrEP or if acute HIV is suspected, laboratory-based HIV 1/2 Ag/Ab testing is recommended.
Documentation Requirements

According to the Public Health Law, the following elements pertaining to HIV testing should be documented in the patient medical record:

- The patient was advised that HIV testing is being done
- If the patient declines the HIV test
- For patients with confirmed HIV infection, the name of the provider/facility with whom the follow-up appointment was made

How often does the offer of HIV testing need to be repeated?

In addition to offering HIV testing once in the course of routine care, testing should be offered annually to patients whose behavior indicates elevated risk. In order to promote early identification, HIV testing may be offered as frequently as every three months to patients with identified risk behaviors. Since many people choose not to disclose their risk behaviors, providers should consider adopting a low threshold for recommending HIV testing.

Requirement for Written or Oral Patient Informed Consent to HIV Testing

Effective November 28, 2016, amendments to the New York State Public Health Law removed the requirement for written or oral informed consent prior to ordering an HIV-related test, including elimination of written consent for HIV testing in New York State correctional facilities, and removing references to consent forms. The objective of the update is to eliminate barriers to HIV testing and make HIV testing comparable to the manner in which other important laboratory tests are conducted. HIV testing remains voluntary and patients have the right to refuse an HIV test, but obtaining written or oral consent for testing is no longer required in any setting. Patients must be advised orally that an HIV test is going to be performed. If the patient objects to the HIV test, this should be noted in the patient’s medical record. HIV test requisition forms submitted to laboratories do not require provider certification of informed consent.

Important Points:

Prior to conducting diagnostic HIV testing, information about HIV must be provided orally, in writing, through signage or in any other patient-friendly audio-visual format. Placing the NYSDOH HIV testing clinic poster in a visible location or providing patients with the NYSDOH patient brochure on HIV testing are simple ways of conveying this information to patients. The key points of information that must be provided are:

- HIV testing is voluntary and all HIV test results are confidential (private)
- HIV can be transmitted through unprotected sex, sharing needles, child birth or breastfeeding
- Treatment for HIV is very effective, has few or no side effects and may involve taking just one pill once a day
- Partners can keep each other safe by knowing their HIV status and getting HIV treatment, or taking HIV pre-exposure prophylaxis (PrEP). Not sharing needles and practicing safer sex will help protect against HIV, hepatitis C and other STDs
- It is illegal to discriminate against a person because of his or her HIV status and services are available to help address discrimination
Anonymous HIV testing (without giving your name) is available at certain public testing sites. HIV testing is a routine part of health care, but you have the right to decline an HIV test; testing will not be performed if you object; if you wish to decline HIV testing, inform the health care provider. If the patient declines the offer of an HIV test, this should be noted in the patient’s medical record. For patients diagnosed as living with HIV, the health care provider administering testing must arrange, with the consent of the patient, an appointment for HIV medical care; simply providing the name of a care provider is not sufficient; a specific appointment with a provider who offers HIV care should be provided.

These new provisions apply to all HIV testing in New York State and not just for testing as offered to people over the age of 13 in clinical settings.

For additional information, please visit the Department’s website nyhealth.gov. Questions may be sent to hivtestlaw@health.state.ny.us.

Expansion of Minor Consent for HIV Treatment and Preventive Services
2017 amendments to NYSDOH’s regulations allow minors to consent to their own HIV treatment and HIV preventive services such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) without parental/guardian involvement (10 NYCRR Part 23). Part 23 has long established the legal capacity of minors to consent to treatment and preventive services for sexually transmitted diseases (STDs). Provisions in Part 23 require that the Commissioner of Health promulgate a list of sexually transmitted diseases. The 2017 amendments to 10 NYCRR Part 23 added HIV to the list of STDs, thereby bringing minor capacity to consent to HIV treatment and preventive services on par with other STDs. In addition, under Part 23, medical or billing records may not be released or made available to the parent or guardian without the minor patient’s permission.

After being diagnosed, young people currently face barriers that can prevent or delay access to care, including denial and fear of their HIV status, misinformation, HIV-related stigma, low self-esteem, lack of insurance, homelessness, substance use, mental health issues, and lack of adequate support systems. Because of these factors, many young people need the ability to consent to their HIV treatment. Updates to regulation help ensure that more young people have optimal health outcomes and prevent transmission of HIV to others. In addition, minors will now have the ability to consent to HIV-related preventive services, including PrEP and PEP just as they can consent for other reproductive or sexual health related services.

Post-test Counseling and Requirements to Link Newly Diagnosed Patients to HIV Care
When testing indicates a diagnosis of HIV infection, the person ordering HIV testing or their representative must provide the patient the final interpretation of diagnostic testing,
and, with the patient’s consent, schedule an appointment for follow-up HIV medical care.

IMPORTANT NOTE: A person with laboratory evidence of acute or early HIV infection (i.e. detectable HIV antigen and virus, but no evidence of HIV antibodies) has a high likelihood of passing the virus to sexual or needle-sharing partners and should be counseled about how to avoid passing the virus to others.

Patient educations should be provided that addresses:

- That the diagnosis means the person is living with HIV, a lifelong health condition
- That people can live a healthy life with HIV; HIV treatment is effective, has few or no side effects and may involve taking just one pill once a day
- That financial assistance is available, if needed, for HIV medical care and HIV medications
- That the patient can pass HIV to sexual or needle-sharing partners and strategies for avoiding transmission; including information about mother-to-child transmission
- The importance of notifying sexual or needle-sharing partners to prevent further transmission and to promote access of exposed persons to HIV testing, health care and prevention services
- The range of partner notification options and available partner services programs
- That names and other information about the patient is not shared during the partner notification process
- That known contacts, including a known spouse, are reported to the health department
- The risk of domestic violence and performance of domestic violence screening using the NYSDOH-approved domestic violence screening protocol
- That HIV-related information is confidential; information may be shared with medical providers to provide needed care but may not be shared with others without patient authorization to release confidential HIV-related information
- That a minor who has been diagnosed with HIV may consent to their own HIV treatment (if applicable)
- That patient authorization to release confidential HIV-related information may be revoked at any time
- That discrimination against persons with HIV in the areas of employment, housing, public accommodations, health care and social services is prohibited by law
- That all cases of HIV infection are reported to the health department
- That if a person with HIV appears to be 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

IMPORTANT NEW INFORMATION: Undetectable equals Untransmittable (U=U):
There are many important reasons to start HIV treatment as soon as possible. In addition to getting treatment to support your own health, a person living with HIV who
is on HIV treatment and virally suppressed for 6 months or longer has effectively no risk of passing HIV to a partner through sex.

A person who tests negative for HIV infection must be informed of the result and provided information concerning the risk of acquiring HIV through sexual and needle-sharing activities. Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) should be discussed as prevention options. This information may be in the form of written materials such as the NYSDOH document titled *Information for Patients with a Negative HIV Test Result*. The negative test result and required information do not need to be provided in person. Other mechanisms such as email, mail, and phone may be used as long as there is an established protocol. Alternative methods of delivering results must be discussed with the patient. It is not appropriate to tell patients that if they are not contacted, they may assume their test was negative.

Patients with potential recent exposure to HIV present diagnostic challenges due to the "window period," or the length of time after infection that it takes for antibodies or the virus to be detected by HIV diagnostic tests. More information about the window period for various types of tests can be found at [www.hivguidelines.org](http://www.hivguidelines.org). Clinicians should be familiar with the testing process used by the laboratory conducting testing for their patients because recommendations for retesting patients with recent exposure will vary depending on the test used.

A person with inconclusive or incomplete HIV diagnostic testing results, i.e., when the HIV Diagnostic Testing Algorithm did not produce an overall valid or conclusive result, shall be informed that the test result was inconclusive or incomplete and have an additional specimen collected as soon as possible. In these cases, the entire algorithm should be repeated. More information is available at:

[www.health.ny.gov/diseases/aids/providers/testing/algorithm.htm](http://www.health.ny.gov/diseases/aids/providers/testing/algorithm.htm)

The New York State Health Department may be able to assist if you have difficulty locating a patient in need of additional testing to resolve inconclusive HIV diagnostic testing.

For additional information visit:

[www.health.ny.gov/diseases/communicable/std/partner_services](http://www.health.ny.gov/diseases/communicable/std/partner_services)

**Universal Recommendation for Testing of Pregnant Women**

New York’s regulatory framework for preventing mother-to-child transmission (MTCT) of HIV has proven highly effective and remains unchanged. The only exception is that the 2017 updates to HIV testing do remove the requirement to obtain consent for HIV testing in writing or orally. All pregnant women must be offered HIV testing as a clinical recommendation as early as possible during pregnancy. Third-trimester testing is recommended for all pregnant women in NYS who tested negative for HIV earlier in their pregnancy. When being offered HIV testing, the woman should be provided the key points of information and informed of her right to decline the test. Pregnant women who are diagnosed as living with HIV should be linked to treatment as soon as possible to protect their health and prevent transmission of HIV to the newborn.
Women who present to the labor/delivery setting with no history of HIV testing during their current pregnancy should be counseled with the recommendation for HIV testing. If the mother declines testing in labor/delivery, the mother should be informed that her newborn will be tested immediately at birth without her consent. All newborns, including those tested at birth, are routinely tested for HIV through the New York State Newborn Screening Program. Documentation of the woman’s prenatal HIV testing should be forwarded to the delivering hospital and a copy of the mother’s HIV test history results should be placed in the newborn’s medical record to ensure administration of medications during labor/delivery and initiation of medication to the infant for the first four-six weeks of life or until the infant is definitively excluded from HIV infection. To access the latest regulations visit:


**Acute HIV infection during pregnancy**
The acute HIV infection in pregnancy guidelines recommend the following:

- Confirmation of preliminary positive expedited HIV test results
- Vigilance for acute HIV infection in pregnant women who present with a compatible clinical syndrome, even if a previous HIV antibody test during current pregnancy was negative
- Evaluation for acute HIV infection in pregnant or breastfeeding women who present with a febrile “flu” or “mono” like illness, or rash that is not otherwise explained
- Immediate screening for suspected acute HIV infection by obtaining an HIV serologic screening test in conjunction with a plasma HIV RNA assay (a fourth-generation HIV antigen/antibody combination test is the preferred serologic screening test, if available)
- Repeat HIV RNA testing from a new specimen to confirm the presence of HIV RNA if HIV RNA or antigen was detected in the absence of HIV antibody
- Baseline genotypic testing and initiation of ART while waiting for the results of resistance testing

**Rapid Test Technology**
Rapid HIV antibody tests that can provide a preliminary* result during a single appointment are recommended. Individuals may be more likely to be tested for HIV if they know that the appointment, inclusive of counseling, consent and testing, will be relatively brief.

*Further testing is always required to confirm a reactive (preliminary positive) screening test result.

Consent for rapid HIV testing can be oral and noted in the medical record.

- Offering of testing during labor and delivery for those who do not have documented third trimester HIV test results
• Availability of expedited testing of pregnant women who present for delivery without documentation of a negative HIV test

In Labor and Delivery Settings, recommendations are:
• Adoption of point of care rapid HIV testing in labor and delivery settings
• Availability of expedited HIV test results prior to delivery to allow maximum benefits of intrapartum ARV prophylaxis for the fetus
• Steps to follow when expedited HIV testing yields a preliminary positive result
• Steps to follow when definitive test results indicate HIV infection is present
• Steps to follow when HIV infection has been definitely excluded in the mother

Additional information about rapid testing is available at the DOH website at:

health.ny.gov/diseases/aids/providers/testing/

Additional Maternal-Pediatric HIV Prevention and Care Program Test History and Assessment can be found on the following site:


AIDS Institute NYSDOH 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 available.

For counseling call 1-800-872-2777
For testing call 1-800-541-AIDS

Special initiatives are available to providers who want 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/general/about/index.htm

Partner Services and the Role of Partner Services Program
Medical providers or their designee must explain to all newly diagnosed patients the importance of notifying any sexual or needle-sharing partners that they may have been exposed to HIV. Partner services is a cornerstone of HIV prevention efforts that provides an opportunity for sexual or needle sharing contacts of a person living with HIV to be offered testing in a timely manner, and if diagnosed with HIV infection, be linked
into care. Every physician or other person authorized to order diagnostic testing is required to report HIV and AIDS diagnoses to the health department. This report must include identifying information about any contacts known to the clinical provider or provided to the clinical provider by the patient. The HIV/AIDS Provider Portal described in Section 7, may be used to report cases (including partners) and to request assistance from the health department with partner notification. As part of post-test counseling, the following must be provided to the patient:

1. An explanation of the importance of notifying sexual or needle-sharing partners to prevent further transmission, and to promote early access of exposed persons to HIV testing, health care, and prevention services
2. A description of notification options and assistance available to the protected individual
3. A discussion about the risk of domestic violence and screening for domestic violence prior to partner notification in accordance with NYSDOH domestic violence screening protocol
4. The fact that known contacts, including a known spouse, will be reported to the health department; that protected persons will also be requested to cooperate in contact notification efforts of known contacts and that protected persons may name additional contacts they wish to have notified with the assistance of the provider or authorized public health officials
5. An explanation that the name and other information about the person living with HIV will be protected during the contact notification process

The NYSDOH Partner Services Program and the NYC Health Department Contact Notification Assistance Program (C-NAP) provide a wide range of services, including: performing notifications; assisting patients with decision making; and consulting with health care providers. In some situations, Partner Services specialists can meet with the patient at the same time that the laboratory results are given to assist with post-test counseling and development of a partner notification plan. Additional NYSDOH/NYC Department of Health and Mental Hygiene (NYCHMH) services may be available, such as assistance in locating persons who test positive but who do not return for their results. For more information about partner services and how to contact partner services programs throughout NYS, visit:


IMPORTANT POINT:
In recognition of the need for ongoing partner services beyond the time of initial diagnosis of HIV, the 2016 updates to the NYSDOH Regulations formally prioritized partner services for people who were previously diagnosed with HIV who are at elevated risk of transmitting the virus to others. Several factors are considered as evidence of elevated risk of transmitting the virus to others. Those factors include that the individual: 1) is not engaged in health care services 2) is not virally suppressed 3) has had a recent STD or 4) has recently moved back to NYS from another jurisdiction.

In addition, the updated NYSDOH Regulations remove the requirement that data on the
partners of HIV cases be destroyed after three years. The NYSDOH or local health department will establish a new policy for record retention and disposition.

**Health Care Provider HIV Reporting Requirements**

New York State Public Health Law Article 21 requires the reporting of persons with HIV infection and AIDS to the NYSDOH. The law also requires that reports contain the names of sexual or needle-sharing partners known to the medical provider or whom the patient wishes to have notified. Under the federal HIPAA Privacy Rule, public health authorities have the right to collect or receive information “for the purpose of preventing or controlling disease” and in the “conduct of public health surveillance…” without further authorization. This provision of HIPAA regulations authorizes medical providers to report HIV/AIDS cases to the NYSDOH or NYC Health Department without obtaining patient permission.

The **Medical Provider HIV/AIDS and Partner/Contact Report Form (PRF) (DOH-4189)** must be completed within 14 days of diagnosis for persons with the following diagnoses or with known sex or needle-sharing partners:

- **Initial/New HIV diagnosis** - First report of testing documenting HIV diagnosis
- **Previously diagnosed HIV (non-AIDS)** - Applies to a medical provider who is seeing the patient for the first time
- **Initial/New diagnosis of AIDS** - Including <200 CD4 cells/μL or an opportunistic infection (AIDS-defining illness)
- **Previously diagnosed AIDS** - Applies to a medical provider who is seeing the patient for the first time
- **Known sex or needle-sharing partners of persons with diagnosed HIV infection**

Clinicians seeing for the first time a patient previously diagnosed with HIV or AIDS should report to the NYSDOH using the PRF. The rationale is that this is often the only indication the NYSDOH receives of a patient new to New York, but not newly diagnosed, and perhaps not in need of extensive Health Department Partner Services. Additionally, particularly for the well suppressed patient who moves into NYS, the report by the clinician can be the only indication that the person is in fact HIV positive.

Information regarding electronic reporting via the HIV/AIDS Provider Portal (see below) or paper forms are available from the NYSDOH at 518-474-4284; clinicians located in NYC, call 212-442-3388. *In order to protect patient confidentiality, faxing of reports is not permitted.*

**HIV/AIDS Provider Portal**

The HIV/AIDS Provider Portal is an electronic system that enables clinicians to: 1) meet their reporting requirements electronically 2) provide a mechanism for clinicians statewide to notify the NYSDOH that a patient needs linkage to Health Department Partner Services and 3) submit inquiries for patients with diagnosed HIV infection who are thought to be in need of assistance with linkage to or retention in HIV medical care. A NYSDOH Health Commerce System (HCS) Medical Professionals account is required. After logging into the HCS at [https://commerce.health.ny.gov/](https://commerce.health.ny.gov/), select
“Refresh My Applications List” on the left side and then under “My Applications” select HIV/AIDS Provider Portal. Follow the prompts to set up an account.

Laboratory Reporting Requirements
Laboratory reporting of suspected or confirmed positive findings or markers of HIV infection is mandated under New York State Public Health Law. Guidance has been prepared in an effort to assist permitted clinical laboratories and blood banks in meeting their obligations to report HIV-related laboratory test results, as well as other communicable disease markers. The guidance is available on the Wadsworth Laboratory website.

HIV laboratory reporting is an essential source of information for New York’s HIV surveillance efforts and maintaining high quality, complete data is critical to tracking progress toward National HIV/AIDS Strategy retention and care measures and New York’s effort to end the epidemic. To keep pace with advances in HIV care, testing technologies and disease monitoring, there have been some important changes to HIV laboratory reporting requirements. Laboratories and blood/tissue banks performing tests for screening, diagnosis or monitoring of HIV infection for NYS residents and/or NYS health care providers (regardless of patient residence) shall report the following laboratory tests or series of tests used in the diagnosis of HIV infection:

- All reactive/repeatedly reactive initial HIV immunoassay results AND all positive, negative or indeterminate results from all supplemental HIV immunoassays performed under the second or third step in the diagnostic testing algorithm, including HIV-1/2 antibody differentiation assay, HIV-1 Western blot, HIV-2 Western blot or HIV-1 Immunofluorescent assay
- All HIV nucleic acid (RNA or DNA) detection tests (qualitative and quantitative), including tests on individual specimens for confirmation of nucleic acid-based testing (NAT) screening results
- All CD4 lymphocyte counts and percentages, unless known to be ordered for a condition other than HIV
- HIV genotypic resistance testing via the electronic submission of the protease, reverse transcriptase and integrase nucleotide sequence
- Positive HIV detection tests (culture, P24 antigen)

All HIV-related laboratory reporting, including by NYC providers and for NYC residents, should be made directly to the NYSDOH, submitted electronically via the NYSDOH Electronic Clinical Laboratory Reporting System (ECLRS).

To improve the quality of data, and in keeping with changes that allow for enhanced use of surveillance data to improve linkage and retention in care, laboratories are required to report results using patient identifying, demographic and locating information, as well as the requesting provider and facility ordering the lab test. The 2016 update requires that when labs report HIV-related test results, the following information should be included:

- Patient name, date of birth, and other identifying information;
- Patient demographic information, e.g., sex at birth, race/ethnicity, etc.
- Patient address and telephone number
- Provider ordering the test and facility name
Complete provider and facility address and telephone number
Provider and facility National Provider Identification

For a complete list of this information and instructions on how to report required data elements, please call 518-474-4284 or contact BHAELab@health.state.ny.us.

Care of HIV Positive Individuals
The NYSDOH AIDS Institute's clinical guidelines 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/

All clinical care settings should be prepared, either on-site or with a confirmed referral, to support patients in initiating antiretroviral therapy (ART) as rapidly as possible after diagnosis.

A new HIV diagnosis is an immediate call to action for every provider who engages with that individual, to assure the rapid initiation of antiretroviral treatment (RIA). New York State Department of Health (NYSDOH) HIV Clinical Guidelines state that treatment is recommended for all patients with a confirmed HIV diagnosis regardless of their CD4 cell count or viral load. All providers serving persons with HIV should establish systems which strive for the same-day initiation of HIV treatment, even while initial lab work is pending. While same-day initiation of treatment may not always be possible, it is ideal that patients be started on treatment within three days. In the outpatient setting, in no instance should treatment initiation take longer than 30 days.

On April 1, 2014, Public Health Law Section 2135 was amended to promote linkage and retention in care for HIV-positive persons. The law allows the New York State Department of Health (NYSDOH) and New York City Department of Health and Mental Hygiene (NYC DOHMH) to share information with health care providers for the purposes of patient linkage and retention in care. The NYSDOH AIDS Institute recommends that health care providers take a multi-pronged approach to support their patients' retention in care, including but not limited to the following:

- Have a proactive patient plan: do not wait for a lapse in care to discuss what to do if the patient becomes lost-to-care.
- Create a patient-centered atmosphere, where all members of the medical care teams, e.g., reception staff, phlebotomists, medical providers, promote patient engagement, linkage, and retention in care.
- When acceptable to patients, expand authorization dates on Authorization for Release of Health Information and Confidential HIV-Related Information forms (DOH-2557) to at least two years. Extending consent timeframes allows collaboration across sectors.
- Have DOD-2557 consent forms on file for every patient. This will permit you to contact community based organizations (CBOs) and others in the event of a lapse in care. Examples of CBOs that can help return patients to care include but
are not limited to: HIV/AIDS CBOs; Health Homes and their downstream providers; food and nutrition programs; shelters; substance use treatment facilities; housing providers; mental health providers; prenatal care providers, etc.

- Encourage patients to add your practice’s name to any releases they sign with other organizations.
- Work with patients to update releases prior to when the releases expire (if applicable).
- Become a member of your area’s Health Home network(s) if you have not already done so, or for more information, go to:

  https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm

Leverage existing resources for patient re-engagement.

- Use information from the Regional Health Information Organization (RHIO), if available, to determine if the patient is in care with another provider or if updated personal contact information is available.
  Conduct a health insurance benefits check, if available, on the patient to determine if s/he changed insurance or is in care with another provider.
- If the patient is in a Managed Care plan, the plan will have updated contact information, recent use of care, and medications on file. If this is a Medicaid Managed Care Plan, the plan can identify which Health Home the patient may be enrolled in and this information may be useful to your follow-up efforts.
- If your patient is enrolled in a Health Home and has signed a release, contact the Health Home to determine whether the patient is actively enrolled. If yes, request assistance to contact or re-engage the patient in care.
- If your patient has Medicaid but has not been enrolled in a Health Home, contact the Health Home to make an “upstream referral.” The patient will be referred to a provider who may conduct outreach to the patient’s home.
- Try multiple modes of contact (phone, text, letter, email, and social media) at varying times of the day/week to reach the patient (special consideration for social media sites – contact patient from an agency social media account and not a staff person’s personal account).
- If your patient uses other services within the facility (e.g., WIC, dental, child’s provider), place an alert on the Electronic Medical Record (EMR) to reconnect to the HIV Primary Care Provider and, if pregnant, to her prenatal care provider.
- As authorized in patient releases and/or medical charts, work with emergency contacts and other agencies/providers to determine whether they have had recent patient contact.
- Conduct a home visit if resources allow. If you have a peer program, utilize peers to provide outreach to the patient’s home.

Use external systems to expand your search when you cannot find a patient.

- Review public records such as:
  - Property tax rolls, municipal tax rolls, etc.:
    http://publicrecords.onlinesearches.com/NewYork.htm
  - Parole Lookup: http://www.doccs.ny.gov/lookup.html
Pregnant women and exposed infants lost-to-care require immediate action for re-engagement.
HIV-positive pregnant women and their exposed infants are a priority when identified as lost-to-care and require immediate action for re-engagement. Reengagement in care is especially important for HIV-positive pregnant women who are in their third trimester due to possible increasing viral loads from being non-adherent to ART, leading to increased risk of transmitting HIV to their infants. Ensuring exposed infants are engaged in care is critical during the first 4-6 months to ensure appropriate antiretroviral and opportunistic infection prophylaxis, as well as definitive documentation of the infant’s HIV infection status.

If routine attempts for reengagement of the HIV-positive pregnant woman or her exposed or infected infant(s) are not successful, please contact the NYSDOH Perinatal HIV Prevention Program at (518) 486-6048 or submit a request via the NYSDOH HIV/AIDS Provider Portal (see below) for assistance. NYC providers should call the NYC DOHMH Field Services Unit at (347) 396-7601 for assistance with reengagement of pregnant women.

For providers based in NYS outside of NYC:
After exploring the investigation tools and strategies listed above and if patient follow-up is warranted, the Bureau of HIV/AIDS Epidemiology (BHAE) may be able to provide information regarding a patient’s care status through the NYSDOH HIV/AIDS Provider Portal. The HIV/AIDS Provider Portal is an electronic system which enables clinicians to:
1) Meet their reporting requirements electronically;
2) Provide a mechanism for clinicians statewide to notify the NYS DOH that a patient needs linkage to Health Department Partner Services; and,
3) Submit inquiries for patients with diagnosed HIV infection who are thought to be in need of assistance with linkage to or retention in HIV medical care.

A NYSDOH Health Commerce System (HCS) Medical Professionals account is required. To apply for an HCS Medical Professions account, navigate to:

https://apps.health.ny.gov/pub/top.html

After logging into the HCS at https://commerce.health.ny.gov/, select “Refresh My Applications List” on the left side and then under “My Applications” select HIV/AIDS Provider Portal. Follow the prompts to set up an account. Urgent requests will be
responded to within 1 business day. For routine requests to the HIV/AIDS Provider Portal, the turn-around time is typically within 1-3 business days.

**Pre-exposure Prophylaxis (PrEP)**

In May 2014, the Centers for Disease Control and Prevention (CDC) released its guidelines for the use of daily pre-exposure prophylaxis (PrEP) for the prevention of HIV infection. The following CDC PrEP documents are available:


The New York State Health Department urges providers to adhere to CDC and New York State guidelines with their patients on PrEP by:

- Testing for HIV every three months using a laboratory-based, ideally 4th generation HIV test;
- Assessing for signs of acute HIV infection at every visit;
- Having a low threshold for testing for acute HIV and STI’s; and
- Encouraging patients on PrEP (or on HIV treatment) to use condoms as often as possible.

Go to health.ny.gov/diseases/aids/general/prep.

**Reporting of Suspected Seroconversion**

Providers who manage patients on PrEP are strongly encouraged to immediately report any cases of suspected PrEP/PEP breakthrough HIV infection as follows:

1. NYC: Report cases to the New York City Department of Health and Mental Hygiene by calling 212-442-3388 and following the directions detailed in the attached Health Alert, or
2. Remainder of state: Report cases to New York State Department of Health by calling 518-474-4284 or using DOH-4189 and contacting the local Partner Services Program to discuss the case.

State law requires that providers report all cases of HIV infection as soon as possible but no later than 14 days after diagnosis. Rapid case reporting is critical, because it allows health departments to investigate the case and engage field staff to:

1. Conduct outreach to the patient’s social network;
2. Make HIV testing available to exposed partners; and,
3. Reduce secondary transmission by expediting linkage to care and PrEP/PEP referrals.

**Tuberculosis Facts and Internet Resources**

Tuberculosis (TB) is a bacterial disease usually affecting the lungs. TB is spread through the air and can affect anyone of any age. Treatment can be complicated and often includes taking medication for three to nine months. For more information:

BlueCross BlueShield Medical Record Review Standards

The Medical Record Review must be conducted and completed as a requirement of participation for specific medical specialties. These medical specialties include, without limitation, the primary care specialties (internal medicine, family practice, pediatrics, geriatrics, and general practice), obstetrics-gynecology, and high volume mental health specialists.

A structural review is conducted to verify that the physical components of the medical record (structure, legibility, and completeness) are acceptable and meet BlueCross BlueShield quality standards. A copy of the tool is available on our secure provider website.

Information Exchange Policy for Primary Care Physicians/Specialists/Facilities

This information exchange policy is established to ensure our practitioners and facilities have the needed health care information to provide coordinated quality health care services to our members. All practitioners, including behavioral health and facilities providing health and behavioral care services to our members, must ensure timely exchange of pertinent medical information. (Consent may be addressed with the member by the office privacy policy or by separate consent to share information).

Time frames for this exchange shall be within 30 calendar days of initial assessment; annually if concurrent care continues for more than twelve (12) months, or more frequently if the member's clinical condition or treatment changes significantly and within seven (7) calendar days of medication change. These guidelines are supported by New York State Mental Health Law, New York State Public Health Law, Centers for Medicare & Medicaid Services (CMS) standards, and the National Committee for Quality Assurance (NCQA) Standards for Accreditation and HIPAA regulations.

Those affected by the policy are primary care practitioners specialists including behavioral health and pertinent ancillary practitioners, health care and home care facilities; and surgical, laboratory, and diagnostic centers.

The guidelines are as follows:

Minimum Information to be exchanged:

1. Primary Care: Practitioner (PCP):
The PCP is required to provide the specialist with pertinent medical information. This should include but is not limited to:
   - Office notes
   - Discharge summaries
   - A formal letter summarizing medical history
   - Diagnostic test reports
   - Other pertinent consult reports and information
2. Specialist:
The specialist is required to provide the member's pertinent medical information to the primary care practitioner, in order to promote optimal coordination of care, regardless of the member's referral method. This should include but is not limited to:

- Diagnosis
- Consultation report or treatment notes
- Diagnostic reports
- Plan of treatment
- Medications prescribed or medication changes
- Other pertinent consult reports and information
- Concurrent care management reports when applicable

3. Facility (including Urgent Care Centers):
Facilities involved in the member's care are required to provide the primary care practitioner with the following:

- Discharge summaries (within 24 hours of facility discharge)
- Diagnostic reports
- Emergency room summaries/reports/notes
- Concurrent care management reports (homecare, skilled, rehab, etc.)

4. Behavioral Health Specialists: Exchange of information may be to another behavioral health practitioner and/or the member’s primary care practitioner with an appropriate signed consent from the member. This includes but is not limited to:

- Diagnosis
- Medications prescribed or medication changes
- Any significant risk status or issues
- Stress related factors
- Treatment recommendations
- Frequency of treatment
- Significant coordination of care issues/medical compliance issues

Medical Record Transfer Policy for Primary Care/Specialists
This record transfer policy ensures that enrollees receive timely continuity of care when changing primary care and/or specialist provider. The guidelines are as follows:

The policy is followed when the:

- Primary care/specialist/behavioral health practitioner leaves the network.
- Primary care/specialist/behavioral health practitioner retires or leaves a practice.
- When an enrollee makes a change to another primary care/specialist/behavioral health practitioner.

Procedure:

- The enrollee must sign a HIPAA-approved medical record release to transfer the record to another physician.
• The primary care/specialist/behavioral health practitioner must provide to the member the provider’s office policy for the release of medical records and, if applicable and permitted by law, what the cost is to the patient.

• The primary care/specialist/behavioral health practitioner is required to send the medical record to the new primary care/specialist/behavioral health practitioner within ten (10) business days of the release. Medical record transfers will be processed more quickly if the enrollee’s medical condition warrants it.

Note: Charging an enrollee for the copying of their medical record is subject to the restrictions contained of Section 17 of New York’s Public Health Law. Any charge, if permissible, must be reasonable and cannot exceed $.75 per page per New York State Law. Moreover, an enrollee cannot be charged for records requested to support an application, claim or appeal for any government benefit or program. An individual cannot be denied access to their medical record information solely because he/she is unable to pay.

Medical Record Retention Policy
All participating practitioners and facilities, including behavioral health practitioners are required to maintain medical and billing records on all covered persons receiving covered services in accordance with the terms and conditions of the participating practitioner’s/facility’s participation agreement, including but not limited to the terms below.

Procedure:
1. The medical record includes but is not limited to:
   a. History and physicals
   b. Demographics
   c. Allergies and adverse reactions
   d. Reports from referring practitioners
   e. Current medication list/medication orders/reconciliation
   f. Discharge summaries
   g. Records of emergency care, hospital care and medical procedures
   h. Diagnostic reporting/preventive services and risk screening
   i. Telephone logs
   j. Progress records (documentation of clinical findings and evaluation for each visit)
   k. Office notes
   l. Flow sheets/problem lists
   m. Immunization documentation
   n. Advance directives
2. The medical record and personally identifiable health information is confidential as applicable to state and federal laws regarding confidentiality of medical records, including without limitation, the Health Insurance Portability & Accountability Act (HIPAA) of 1996.
3. Records shall be maintained in accordance with prudent record keeping procedures and as required by practice standards and law.
4. Records for all covered persons must be maintained for the greater of:
• For covered persons (other than persons enrolled in Medicare Advantage or Medicaid prepaid coverage plans or children’s health program agreements between the health plan and CMS), for no less than six (6) years following termination, four (4) years past the age of majority, or six (6) years past the date of service, whichever is longer.

• For covered persons enrolled in a Medicare Advantage contract, for no less than (10) years following conclusion or termination of the applicable Medicare Advantage contract or from the date of completion of any audit by CMS, the U.S. Department of Health and Human Services, the comptroller general and/or their designee, whichever is later, unless any of the following:
  o CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies the health plan or the participating practitioner/facility at least thirty (30) days prior to the normal disposition date.
  o CMS determines there is a reasonable possibility of fraud or similar fault by the health plan or the participating practitioner/facility, in which case the retention period may be extended for six (6) years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault.
  o CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate and audit the health plan and/or the participating practitioner/facility at any time.

• The time period required pursuant to applicable law

Access to all stated records and billing files by:
  • BlueCross BlueShield of Western New York
  • Any Plan IPA for Utilization and Quality purposes
  • New York State Department of Health
  • CMS
  • Local Department of Social Service

For Medicaid Managed Care Plans

  • Separate medical record for each enrollee.
  • The record verifies that PCP coordinates and manages care.
  • Medical record retention period of six years after date of service rendered to enrollees and for a minor, three years after majority or six years after the date of the service, whichever is later.
  • Prenatal care only: centralized medical record for the provision of prenatal care and all other services.
Access to Medical Records

Participating Physician shall maintain and make available, upon request and at no charge, Participating Physician's books, records and papers and covered Person medical records that relate to the provision of health care services to Covered Persons and copies thereof to Health Plan, appropriate state and federal authorities and their authorized representatives, for purposes that include, but are not limited to, determining payment issues; facilitating audits; assessing quality of care, quality improvement or Medical Necessity; complying with various reporting requirements, e.g. HEDIS and NCQA, outcome studies and demand management programs; and determining the appropriateness of care provided to Covered Persons. Participating Physician further agrees to provide Covered Persons, or their duly authorized representatives, copies of their medical records promptly upon written request.

Participating Physician acknowledges that, consistent with applicable law, the consent contained in Covered Person's Coverage Plan is sufficient consent for the disclosure of the Covered Person's medical records to Health Plan. Upon request, Health Plan shall be permitted to review and audit such records at the Participating Physician's office and to inspect Participating Physician's facilities.

Participating Physician agrees to make such records and facilities available, upon request, to appropriate state and federal authorities and their authorized representatives, including, but not limited to, the New York State Department of Health, for the purposes of inspection and photocopying, at no charge to such regulatory authorities.

Participating Physician acknowledges and agrees that Health Plan, or its designee, may use statistical samples and other appropriate external audit and fraud and abuse detection practices and methods in conducting audits pursuant to this section.

Access to Care Policy

Access to care policy for physician appointments is established to ensure BlueCross BlueShield members’ timely accessibility to health and behavioral care services. Services are provided in a culturally competent manner and are accessible to all enrollees. These guidelines are supported by NCQA Standards for Accreditation and the New York State Medicaid Standards for Participation. The guidelines are as follows:

For Primary, Specialist and OB-GYN Care

- After-hours access including emergent life threatening and urgent conditions in new and established patients: practitioner should employ a 24-hour, 7-days-a-week “on call” telephone resource that includes access to a “live voice” via an answering service, answering service with the option to page the practitioner, an advice nurse with access to the practitioner, access to the practitioner auto-pager
or an answering machine/voicemail system with appropriate after hours instructions for patients.

- The patient should either receive an immediate response or be instructed on what to do to obtain services after hours and on weekends. Answering machine/voicemail instructions should include an anticipated timeframe in which the patient could expect a return call. Patient calls cannot be routinely referred to an emergency room.

- Urgent medical or behavioral problems: an appointment should be scheduled within 24 hours, based on symptoms and physician judgment.

- Members with an appointment should not routinely be made to wait longer than one (1) hour.

- Telephone access for physician offices:
  - Phones should be answered promptly.
  - If the office has an automated telephone directory, there should be a prompt for emergency situations that allows the caller to speak to someone.
  - If the caller is to be placed on hold, the person answering the telephone must assess for an emergency before placing the caller on hold.
  - A caller should not be on hold for more than three (3) minutes without someone checking on them.

**Primary Care**

- Urgent medical or behavioral problems: An appointment should be scheduled within 24 hours, based on symptoms and physician judgment.

- Follow-up after an emergency or hospital discharge for medical, mental health or substance abuse conditions: An appointment should be scheduled within five (5) days of discharge or as clinically indicated.

- Non-urgent sick visits: an appointment should be scheduled within 48 to 72 hours, based on symptoms and physician judgment.

- Non-acute, symptomatic conditions in new and established patients: an appointment should be scheduled within one (1) to four (4) weeks based on symptoms and physician judgment.

- Routine, non-urgent or preventive care visits: an appointment should be scheduled within four (4) weeks.

- Adult base line and routine physicals: an appointment should be scheduled within twelve (12) weeks.

- Specialist referrals (non-urgent and non-behavioral health): within four (4) to six (6) weeks.

- Provider visits to make health, mental health and/or substance abuse assessments for the purpose of making recommendations regarding recipient's ability to perform work when requested by LDSS should be scheduled within ten (10) days of request by Medicaid Managed Care enrollee.

- Well child care: an appointment should be scheduled within four (4) weeks of request.
Specialist
- Urgent medical problems: An appointment should be scheduled within 24 hours, based on symptoms and physician judgment.
- For non-acute symptomatic conditions in new and established patients, an appointment is scheduled, based on symptoms within one (1) to four (4) weeks.
- For routine, non-urgent or preventive care visits, an appointment is scheduled within four (4) weeks of request.
- Follow-up after an emergency or hospital discharge for medical conditions: An appointment should be scheduled within five (5) days of discharge or as clinically indicated.
- Members with an appointment should not routinely be made to wait longer than one (1) hour.

OB and GYN care
- Urgent medical: An appointment should be scheduled within 24 hours, based on symptoms and physician judgment.
- Non-acute, symptomatic conditions in new and established patients: an appointment should be scheduled within one (1) to four (4) weeks based on symptoms and physician judgment.
- Routine, non-urgent or preventive care visits: an appointment should be scheduled within four (4) weeks. Members have direct access to a women’s health specialist for covered routine and preventive services.
- Initial Family Planning: within two (2) weeks.
- Initial prenatal visits: during first trimester, an appointment is scheduled within three (3) weeks of diagnosis of the pregnancy, within two (2) weeks during the second trimester, and within one (1) week during the third trimester.
- Initial visits for newborns to their primary medical home: an appointment should be scheduled within two (2) weeks of hospital discharge.
- Postpartum visit: should be scheduled twenty-one (21) to fifty-six (56) days after delivery.

Behavioral Health Care
Behavioral Health practitioners include Psychiatrists, Psychologists, Clinical Social Workers, Community Mental Health Centers, and Chemical Dependency Treatment Centers.
- After-hours access including emergent life threatening and urgent conditions in new and established patients: practitioner should employ a 24-hour, 7-days-a-week “on call” telephone resource which may include: access to a “live voice” answering service, answering service with the option to page the practitioner, access to the practitioner auto-pager or an answering machine/voice mail system with appropriate after-hours instructions for patient on how to obtain services. Instructions may include referral to a community 24-hour crisis services hotline. Emergent patient calls may be referred to an emergency room or community 24-hour crisis services hotline.
- Emergent life threatening appointments are triaged immediately
- Emergent non-life threatening behavioral health conditions: Assessment and care should be rendered within six (6) hours.
• Urgent behavioral health problems: an appointment should be scheduled within 24 hours, based on symptoms and physician judgment.
• Non-urgent mental health or substance abuse visits within ten (10) business days of request or as clinically indicated.
• Follow-up routine behavioral health care appointments, for adults and pediatric members are scheduled to monitor/evaluate progress and/or changes that may have occurred since a previous visit. Follow-up visits are scheduled based on individual member need, condition and practitioner assessment/treatment plan.
• Established, stable medication management visits may be scheduled every three (3) to six (6) months.
• For members with depression, at higher risk or newly diagnosed, visits may be scheduled as often as weekly or biweekly based on practitioner assessment and treatment plan.
• Counseling or psychotherapy visits with a non-prescribing practitioner may be scheduled once monthly.
• Follow up after an emergency or hospital discharge for medical, mental health or substance abuse conditions: an appointment should be scheduled within five (5) days of request or as clinically indicated.
• Provider visits to make health, mental health and/or substance abuse assessments for the purpose of making recommendations regarding recipients’ ability to perform work when requested by LDSS should be scheduled within ten (10) days of request by Medicaid Managed Care enrollee.
• Members with an appointment should not routinely be made to wait longer than one (1) hour.

Adherence to this policy is monitored during the provider attestation review, after-hours audits, as well as member complaint evaluations and member satisfaction surveys. Corrective action is instituted as necessary for practitioners who do not achieve a compliant after-hours audit or attestation review. Health Care Quality Improvement (HCQI) Department staff coordinates follow up with the practitioner office and Provider Support Department as needed.

Patient Confidentiality in the Practitioner's Office
A patient confidentiality policy for practitioner’s offices, including behavioral health practitioners, ensures privacy of health information for BlueCross BlueShield members. These guidelines are supported by the NCQA Standards for Accreditation. The guidelines are as follows:
• Staff should avoid discussing patient cases where they can be over heard by others.
• When voices can be heard easily through exam room walls, adding sound proof panels or soft music can help but is not required.
• Arrange office space to allow privacy for your patients who are paying bills and making appointments.
• Ensure computer screens that contain patient information are protected from general view.
• Ensure all patient care is provided out of sight from other patients (weighing, lab draws, etc.).
• Avoid listing patient telephone number or reason for visit on the sign-in sheet.
• Office staff receives periodic training in patient information confidentiality. Have an office Confidentiality Policy for staff to read and sign.
• Ask your patients to sign a HIPAA-compliant Authorization to Release Information form prior to releasing medical records to anyone (other physicians, Department of Health etc.).
• Information containing the HIV/AIDS status, or substance abuse, must have a separate release form stating the practitioner has the permission of the patient to send that information.
• BlueCross BlueShield may obtain members’ medical records, as all members sign an agreement regarding this upon enrollment with BlueCross BlueShield. Providers are not required to release a patient’s HIV and substance abuse information to BlueCross BlueShield without patient authorization.
• Set in place a protocol for sending and receiving confidential information via fax.
• Ensure medical record files are organized and stored in a secure manner that allows for easy retrieval by authorized personnel only. Records should not be accessible to the public.
• Ensure electronic medical records are secured by individual passwords for each practitioner/staff member.
• Keep medical records the staff is working on out of view of others.¹

Child/Teen Health Plan Services (EPSDT)  
(for Medicaid)
The following describes the State’s plan for ensuring that the contracted Managed Care Organizations (MCOs) provide the full range of Child/Teen Health Plan Services. The Child/Teen Health Plan is the New York State Department of Health version of the Federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

Child/Teen Health Plan (C/THP) Requirements
C/THP services are included in the prepaid benefit package for children and adolescents up to 21 years of age. The provision of C/THP services is one of the State’s highest priorities under The Partnership Plan. In accordance with the provisions of the MCO RFP, MCOs are mandated to do at least the following with respect to all members under age 21:

• Educate pregnant women and families with children and young adults under age 21 about the program and its importance to their health;
• Educate network providers about the program and their responsibilities under it;
• Conduct outreach activities, including by mail, telephone, and through home visits where appropriate, to ensure 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;

¹ Adherence to this policy is evaluated during the provider attestation review and through evaluation of member complaints.
• Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a C/THP screen;
• Achieve and maintain an acceptable compliance rate for screening schedules during the contract period.

The annual report from the Quality Assurance Reporting Requirements is released in the fall following the reporting year. For example, the 2005 data was released in a report in the fall of 2006. Trends for measures are part of the report, and the data is used to target managed care plan-specific quality improvement areas. Beginning with data from 1997, managed care plans were required to submit a plan of correction for measurement areas that are below statewide averages and norms.

MCOs are also required to demonstrate that they have adequate numbers of providers, including pediatric providers, geographically distributed in proximity to where members live. The State has incorporated MCO compliance with EPSDT requirements (using well child measure performance) in the auto-assignment algorithm for year two of the program.

Any new partial capitation plans approved by the State will be required to assume the responsibility and financial risk for the provision of C/THP services.

**Monitoring: QARR Requirements**
To enhance its ability to monitor compliance with the C/THP standards, the State continually revises its Quality Assurance Reporting Requirements (QARR), adding or modifying measures to provide more comparable and complete information. QARR measures may be modified or changed from year to year of the program, to reflect both advances in the technology and methodology of measuring quality and new program priorities. The following measures are required to measure compliance with the C/THP standards:

• **Well Child Visit:** The purpose of this measure is to determine the percent of children who turned age 15 months during the reporting year who received 1, 2, 3, 4, 5, or 6 well-child visits with a primary care provider in their first 15 months of life. The C/THP specifies that infants from birth to 12 months of life should have received 6 wellness/preventive visits.
• **Lead Screening:** The purpose of this measure is to determine the number of children who have received one blood screening test for lead poisoning by age 25 months. Regardless of exposure risk, all children must be screened with a blood lead test at or around 12 months and 24 months of age.
• **Well Child Visits for Children 3, 4, 5, or 6 Years of Age:** The purpose of this measure is to determine the percentage of children between 3 years and 6 years of age, who received a well child visit with a primary care physician during the reporting year. The C/THP recommends one wellness visit each year at the ages of 4, 5, and 6.
• **Well-Care Visits for the Adolescent and Young Adult (ages 12 to 21 years):** The purpose of this measure is to determine the percentage of enrollees, aged 12 to 21, who have had at least one well-care visit with a primary care provider during the reporting year.
• Immunizations: The purpose of the immunization measure is to assess the immunization levels of children aged two for the provision of the following antigens: 4 Diphtheria/Tetanus/Pertussis containing vaccines; 3 Polio vaccines; 1 Measles/Mumps/Rubella (MMR) vaccine; at least 3 H Influenza type B vaccines; 3 Hepatitis B vaccines and 1 Varicella vaccine. Individual antigen information collected from plans allows for the flexibility of reporting 4-3-1-3-3-1 immunization rates as well as specific rates of compliance.

• Use of Appropriate Medications for People with Asthma: The purpose of this measure is to determine the percentage of children ages 5 to 17 years with persistent asthma who received appropriate medication to control their condition.

• Annual Dental Visit: The purpose of this measure is to determine the percentage of children and adolescents ages 2 through 21 years, who had at least one dental visit within the last year.

• Appropriate Treatment for Upper Respiratory Infection: The purpose of this measure is to determine the percentage of children ages 3 months to 18 years, who were diagnosed with an upper respiratory infection (common cold) and who were not given a prescription for an antibiotic.

• Appropriate Testing for Pharyngitis: The purpose of this measure is to determine the percentage of children, ages 2-18 years, who were diagnosed with pharyngitis, were prescribed an antibiotic, and who were given a group A streptococcus test.

• Adolescent Preventive Care Measures: The purpose of this measure is to determine the percentage of children, ages 14 to 18 years, who received six components of preventive care during well-care visits. These components include BMI (body mass index), nutrition and physical activity, sexual activity, depression, tobacco use, and substance use.

The Department of Health uses the QARR measures and MCO encounter data to determine any patterns that may indicate that a particular MCO is not providing C/THP services, and to determine if MCOs achieve an acceptable rate of compliance with C/THP services. MCOs that do not achieve an acceptable rate will be subject to corrective measures. More specifically, any MCO that does not achieve an acceptable rate of compliance will be required to perform a root cause analysis and to develop an improvement plan approved by the Department.

Health Care Proxy

It is a Medical Record Standard that primary care physicians have documentation of discussing the need for a health care proxy, or a copy of the completed form, for each adult patient.

To obtain information about the form, review frequently asked questions, and obtain a copy of the Health Care Proxy Form and instructions for completion, or to obtain a copy of the form in English, Spanish, Chinese, or Russian go to: health.ny.gov/professionals/patients/health_care_proxy/
Office Compliance Attestations
A review of primary care physicians, obstetrics/gynecology physicians, mental health specialists’ and oncology office locations must be conducted and completed as a requirement of participation. The physician attestation review addresses, at a minimum: access to services, waiting area amenities, safety and adequacy of equipment, treatment area and after-hours telephone calls. The physician attestation review form and evaluation process are used for this purpose.
Section 12 - Product Information

General Information

BlueCross BlueShield offers a wide variety of health coverage options, including managed care, preferred provider organization (PPO), point of service (POS) and traditional contracts to employer groups throughout western New York.

BlueCross BlueShield has removed the referral requirement from most of our managed care lines of business. This no-referral policy applies to all specialty services provided in-network. Please note the following:

- BlueCross BlueShield continues to encourage members to consult with their primary care physician (PCP) regarding their choice of specialty provider prior to visiting a specialist.
- For continuity of care, specialists must continue to communicate with the PCP about any treatment that is provided.
- Any services that currently require preauthorization will still require preauthorization.
- Benefit coverage and limitations have not changed. For example, if only 20 physical therapy visits were covered with a referral, only 20 visits will continue to be covered.
- This change is for In-Network referrals only. The current referral process will continue to apply for Out-of-Network situations, including out-of-plan referrals. The only exception is for emergencies.

Note: Some products may require a referral, for example Government programs. Please verify eligibility and benefits at wnyhealthenet.org.

HMO and POS

Our managed care contracts provide coverage for preventive and health maintenance care, early diagnosis and treatment, as well as coverage for illness and injury.

In a managed care environment, the PCP manages the member's care. The PCP is responsible for coordinating care and must contact BlueCross BlueShield to obtain referrals and preauthorization when required by the member's benefit package.

HMO and POS Features

Copayments/Coinurance
The provider may not bill the member for services covered except for any applicable copays, co-insurance, or permitted deductibles. A copayment, or copay, is a set amount paid to the provider by the member at the time of service. This amount is deducted from the reimbursement we make to you. Some of the services that require copayments are office visits, emergency room visits, diagnostic services, hospital admissions and therapies. Copayments vary depending on the type of contract, provider (PCP or
specialist) and service involved. Office visit copayments appear on most member identification cards.

In some cases, members are responsible for a coinsurance for covered services. Providers should submit the claim to BlueCross BlueShield for processing and then collect from the member their responsibility. Some products also have deductible amounts prior to copayments or coinsurance being applicable. Providers should submit the claim to BlueCross BlueShield to determine the member responsibility.

Please note if you are a BlueCross BlueShield specialist covering for a PCP, you should collect the specialist copay. OB-GYNs should collect the PCP copayment.

Out-of-Network Benefit
The Out-of-Network benefit gives our members the flexibility to see any doctor without a referral. This benefit provides traditional-style coverage if a member chooses to go outside the network of participating providers to seek care. The member is responsible for a deductible and coinsurance on Out-of-Network services.

This benefit applies to POS products, PPO products and most HMO 200 Series products and is offered as an option to groups who have HMO100 Series products.

Administrative Services Only (ASO)

This coverage is designed for employers who choose to self-fund their employee health benefit programs. Self-funding allows businesses to design their own benefit plans and pay their own claims. BlueCross BlueShield handles the administrative services such as processing claims and developing provider networks. Payment is made according to the fee schedule and all protocols apply. The copayment will vary depending on the group. There is no withhold deducted from the allowance for physicians who provide services to a BlueCross BlueShield member who has an ASO contract. For more detailed information on benefits and claims processing, please call the Provider Service Department at 1-800 950-0052.

Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO) Contracts

PPO and EPO contracts are designed for consumers with indemnity insurance who are looking for an option that does not include the gatekeeper and who want a national provider network.

The PPO concept offers a preferred provider network for members' use. Selection and use of a network physician provides a richer benefit for the member than use of an Out-of-Network provider. The member decides which physician or facility to use. EPO contracts only provide coverage through the exclusive provider network. If a member utilizes a non-network provider, there is no coverage for those services, unless it is an emergency.
The PPO and EPO provider network is based upon the HMO 200 Series panel of physicians. Services are reimbursed at the BlueCross BlueShield fee schedule; however, there will be no withhold, no referrals required and the member is not required to choose a PCP. The patients covered under this product are not included in risk or incentive programs.

The managed care features of this product consist of the BlueCross BlueShield Protocols, inpatient and certain outpatient preauthorization requirements and copayments.

If a PPO member chooses to receive care from a physician who is not participating with the PPO network, the services are considered Out-of-Network. Payment will be made at a percentage of the traditional fee schedule. The member is responsible for the remaining percentage of the traditional fee schedule and the deductible. Participating traditional providers can only bill the member up to the traditional allowance and the amount that is applied to the deductible. EPO members are responsible for the full cost of services when receiving care outside of the EPO network.

Medicaid Managed Care
As a participating provider it is your responsibility to verify at the time of service if the member is eligible for Medicaid Managed Care by accessing the Electronic Medicaid Eligibility Verification System (EMEVS). If you provide services to an ineligible person you may not receive payment for these services.

Below is a list (not complete) of Services that are covered and non-covered for Medicaid Managed Care (MMC). Certain non-covered services for MMC may be covered through the Medicaid Fee for Service Program.

Medicaid Managed Care members have no Out of Area benefits except for ER, inpatient admissions through the ER and authorizations through Utilization Management due to inability or lack of network providers to deliver care.

Medicaid Managed Care: Covered Services
The following services are covered by BlueCross BlueShield when provided by the PCP or arranged by the PCP:

- Assertive Community Treatment (ACT)
- Comprehensive Psychiatric Emergency Program (CPEP)
- Consumer-directed personal care services
- Continuing Day Treatment (CDT)
- Crisis Intervention
- Dental, including medically necessary orthodontia
- Detox Services
- Durable medical equipment
• Emergency services
• Eye care
• Family planning
• Home health services
• Hospice services
• Inpatient hospital services
• Inpatient Substance Use Disorder Treatment
• Laboratory services
• Medical supplies
• Mental Health Clinic
• Mental Health Inpatient Rehabilitation
• Mental health services
• Opioid Treatment (including Medically Assisted Treatment - MAT)
• Outpatient Clinic
• Partial Hospitalization
• Personal care services
• Personal Recovery Oriented Services (PROS)
• Physician services – primary and specialty
• Prescription drugs
• Preventive health services
• Private duty nursing
• Residential Services
• Substance use disorder services

Medicaid Managed Care: Non-Covered Services
The following services are covered through Medicaid fee for service and not BlueCross BlueShield:
Emergent and non-emergent transportation
(NYS Medicaid contracts with Medical Answering Services for Non-Emergent Transportation Services.)

Medical Answering Services contact numbers:

Allegany County       1-866-271-0564
Cattaraugus County    1-866-371-4751
Chautauqua County     1-855-733-9405
Erie County           1-800-651-7040
Genesee County        1-855-733-4430
Niagara County        1-866-753-4430
Orleans County        1-866-260-2305
Wyoming County        1-855-733-9403

Important Phone Numbers
BlueCross BlueShield Member Services       1-866 231-0847
Member Services                          TTY 711
New York State Health Department complaints  1-800-206-8125
Allegany County Department of Social Services  (585) 268-9300
Cattaraugus County Department of Social Services  (716) 373-8077
Chautauqua County Department of Social Services  1-877 653-0216
Erie County Department of Social Services  (716) 858-6105
Genesee County Department of Social Services  (585) 344-8502
Niagara County Department of Social Services  (716) 278-8400
Orleans County Department of Social Services  (585) 589-3209
Wyoming County Department of Social Services  (585) 786-8900

Traditional Contracts

Our traditional contracts provide comprehensive hospital and medical coverage. These contracts cover inpatient medical care, outpatient services such as emergency room visits, outpatient surgical care and pre-admission testing. Covered medical services include hospital visits, most surgery and surgical assistance, maternity care, non-routine lab and radiology procedures.

Members can choose to receive care from any doctor in Western New York. However, members who select a non-participating provider have to pay a higher out-of-pocket cost. Providers who participate in our traditional programs are required to bill us directly and accept our allowances as payment in full for covered benefits after the deductible and coinsurance has been met.

High-Deductible Health Plans

We offer a number of high-deductible health plans (HDHPs) that can be purchased and utilized with a health savings account (HSA) or health reimbursement arrangement (HRA). Deductible, contribution, and out-of-pocket limits are defined by the IRS for HSA accounts. Providers must bill for services rendered and BlueCross BlueShield will calculate the member responsibility (deductible, copay, coinsurance).

Chiropractic Services

Chiropractic care is managed by BlueCross BlueShield. Many traditional and managed care members receive chiropractic benefits due to a New York State chiropractic mandate. This mandate requires contracts that cover services provided in a physician's office to also cover medically necessary chiropractic care received from a licensed physician or doctor of chiropractic. Coverage includes spinal manipulation or adjustment of the spinal column and x-rays that relate to chiropractic treatment. Routine wellness and maintenance care visits are not considered to be medically necessary and are not covered.

The mandated chiropractic services do not apply to the following contracts:

- Medicare Supplemental Plans
- Medicaid MCO 501
- Federal Contracts
• Child Health Plus 201
• Self-insured Plans, unless employer group arranges for coverage (Administrative Services Only - ASO)
• Senior Blue HMO - the mandate does not apply

How the Mandated Chiropractic Benefit Works
For Managed Care contracts
Members may seek care from any participating network chiropractor without a referral from their primary physician. For each visit, members are responsible for the applicable copay and/or coinsurance.

For PPO, EPO, and Traditional Contracts
Members may seek care from any chiropractor. We will reimburse these chiropractic services at our schedule of allowances, subject to any applicable copay, deductible and/or coinsurance. Chiropractors who do not participate with BlueCross BlueShield may balance bill members.

Participating BlueCross BlueShield providers will receive direct payment. For members who seek treatment from a non-participating provider, the member will receive direct payment.

For ASO Self-funded contracts:
Preauthorization is required for members with contractual chiropractic visit limitations. For these members, providers need to submit a completed Chiropractic Treatment Request (CTR) form to our Utilization Management Department. After the medical necessity determination has been made, the provider and member are notified within three days. If additional chiropractic visits are required, the provider must submit additional CTR forms.

Chiropractic Claims:
Submit claims electronically through your vendor or directly to ASK EDI.
If unable to submit electronically, send paper claims to:
BlueCross BlueShield of Western New York
PO Box 80
Buffalo, NY 14240-0080

If you have any questions about covered chiropractic services, preauthorization, or claims submission, please call BlueCross BlueShield at the number identified on the back of the identification card.

Please see the Chiropractic Section of our provider website for additional information including a Chiropractic Reference Manual, and necessary forms.
Laboratory Services

Referred laboratory services provided to our members must be performed by a provider participating with our laboratory network. Please refer to the most recent participating laboratory location guide on our website.

If your patients have coverage under the following BlueCross BlueShield of Western New York plans, laboratory tests must be performed at a Quest Diagnostics Lab in order for services to be covered at the in-network benefit.

- HMO
- POS
- HMO/POS
- Medicare Advantage HMO
- Essential Plan

If the test is not performed at a Quest Diagnostics lab, claims for members in the above plans will be processed under their out-of-network benefit and the member will have higher out-of-pocket costs. Claims for HMO members without POS benefits will be denied.

Out-of-Network Preauthorization Requests

- For testing that cannot be performed by Quest Diagnostics, the ordering physician must request an out-of-network preauthorization by calling Quest Diagnostics at (716) 568-5253.
- Quest Diagnostics will confirm that the testing cannot be performed by their laboratory and is FDA approved; Quest will forward the request to our Utilization Management Department for review.
- Utilization Management staff will determine if the services are medically necessary and, when applicable, approve the out-of-network preauthorization to a non-participating lab so that claims will process at the in-network benefit.

BlueCross BlueShield of Western New York members in the above plans do not have to use a Quest Diagnostics Lab for the following:

- Testing performed during an inpatient admission.
- Pre-admission or pre-surgical testing performed prior to an inpatient stay or outpatient surgery.
- Test associated with an emergency room visit.
- Certain testing that physicians/hospitals may perform. (See Laboratory Exempt Lists on our website.)
BlueCross BlueShield of Western New York policy for continued referrals of laboratory specimens by participating providers to a non-preferred laboratory for the plans above, or to a non-participating laboratory for all plans include the following measures:

**First Occurrence:**
BlueCross BlueShield (BCBSWNY) will contact the provider/group office via email or phone and educate on the requirement to refer specimens to a participating laboratory or the preferred laboratory (Quest Diagnostics) as applicable for the member’s plan or product. Then BCBSWNY will send a 1st notice letter via Certified Mail to the provider/group as a follow-up to the original e-mail or phone conversation (reference contract section 2.3.1 and 2.10.4).

**Second Occurrence:**
BCBSWNY will send a 2nd notice letter via Certified Mail to the provider/group (contract references 2.3.1 and 2.10.4). Financial consequences are noted in the letter.

**Third Occurrence (final notice):**
BCBSWNY will send a 3rd and final notice letter via Certified Mail to the provider/group (contract references 2.3.1 and 2.10.4). The letter needs to include the date that the previous letter was sent. **Financial consequences that would be applicable are noted in the final notice letter, if the third occurrence is within the 12-month time from the first occurrence.**

**Vendors**

To better meet the health needs of our members, BlueCross BlueShield contracts with vendors who have expertise in certain specialties. Working with outside organizations helps BlueCross BlueShield more effectively manage health care costs, while continuing to provide members with high quality care.

**MRI, PET, CT Scans, Nuclear Cardiology, and Radiation Oncology Program**
National Imaging Associates (NIA) manages the preauthorization process for MRI/MRA, PET Scans and Radiation Oncology Program for all BlueCross BlueShield lines of business (unless specified per the member’s contract).

To obtain a preauthorization for these services, you can submit your requests 24 hours a day, seven days a week at radmd.com or contact their dedicated provider call center at 1-800-642-7820. This center is staffed with physicians, on call from 8 a.m. - 8 p.m. EST, Monday through Friday.

**Palladian Health® an eviCore healthcare Company Spine Pain Management Program**
As of April 15, 2016, Palladian Health provides preauthorization for high cost spinal procedures for our commercial* and Medicare Advantage members, 18 years of age and older.
Prior to any spinal procedure, you must ensure patient eligibility by calling our provider service department at 1-800-950-0051 or (716) 884-3461.

About the Palladian Health an eviCore healthcare Company Spine Pain Management Program
The Palladian Health Spine Pain Management Program addresses musculoskeletal conditions using a multi-disciplinary approach, including patient and provider resources. The goal is to ensure that patients are well-informed, engaged in the decision-making process, and receive the most appropriate treatment for their conditions.

*This program excludes ASO, self-funded, alternate-funded products, FEP, Blue Card (Host), Medicare supplement, Child Health Plus, and any chiropractic, physical therapy, and occupational therapy services.

Registration with Palladian Health
Providers must register online to participate in the program. After registration is complete, you will be able to view clinical guidelines, access required intake forms, and preauthorize procedures.

To register:

1. Go to portal.palladianhealth.com
2. Click Register Now at the bottom of the page
3. Enter access code HNNYCSC and click Submit
4. Select Provider
5. Complete the required fields
6. Click Register Account

Palladian Health Evidence-based Clinical Guidelines
Spinal clinical guidelines are available on the Palladian website. These guidelines have been developed from practice experience, literature review, and specialty criteria sets. The following clinical intake forms must be submitted online in order to obtain preauthorization:

- Provider Treatment Form
- SF12 – Patient Outcomes Form

Preauthorization Process for Spinal Procedures
The spine specialist determining the treatment plan and providing the spinal procedure is responsible for requesting preauthorization at portal.palladianhealth.com. Preauthorization requests can be submitted at any time. To expedite the process, you should have all of the following information available before logging on to the Palladian Health website:

- Forms completed by both patient and provider
- Primary CPT code
- Indicator or reason for the procedure
- Patient’s name, DOB, and ID number
You can check the status of a preauthorization request at portal.palladianhealth.com using a seven-digit Palladian Health tracking number (not the same as a BlueCross BlueShield preauthorization number) provided at the time of the request. After a determination is made, Palladian Health will provide confirmation of medical necessity review and approval via fax and phone call.

You can also verify a preauthorization on the Palladian Health website. A preauthorization is valid for 90 days from the date of request.

Identification Cards
It is important to check your patient's insurance card to identify changes since their last visit to keep your records current and to ensure that you submit claims to the correct insurance carrier.

Members will have a prefix on their identification card. The first two letters "YJ" indicates that the member is enrolled with BlueCross BlueShield. The third letter of the prefix will vary to indicate the member's type of coverage.

ASO (Administrative Services Only) Accounts
Prefixes for ASO accounts may be different. To verify benefits and eligibility, go to wnyhealthenet.org or call the telephone number on the member’s card.

National Accounts
Prefixes for national accounts may be different. The corporate name may appear on the member's identification card. For questions on benefits, eligibility, payment method, and claim inquiries for national accounts call the National Accounts telephone number at 1-877-576-6440.
Section 13 - Claims and Billing

Electronic Billing

Electronic claim submission is an easy way to minimize the amount of time it takes your claim to reach and be processed by the health plan. Submitting claims electronically will also save you money by reducing what you spend on orders for paper claims and high postage fees.

BlueCross BlueShield contracts with Administrative Services of Kansas, Inc. (ASK) to be our vendor for this service. ASK will receive all provider claims submissions and will perform any necessary edits to ensure the claims meet all regulatory and contract requirements. The claims will then be transferred to the health plan for adjudication and payment.

ASK was selected because of their experience and credibility in the Electronic Data Interface (EDI) marketplace. We have chosen this company to be our partner in achieving the electronic transaction component of HIPAA.

Enrolling with ASK
To obtain information on or sign up for Electronic Claims Submission with ASK, please visit their website, located on the Internet at ask-edi.com. Click on “Forms” on the left menu.

The enrollment package can be downloaded from the website. Please fill out the online form completely to register and send it directly to the ASK for processing. If you would like to contact ASK by phone, please call their toll free number at 1-800-472-6481; press option 1 for New York Customers and select option 1 again to connect to an EDI Helpdesk specialist.

Click the ‘Resource Center’ tab for:
- Payer News
- General Information
- CAQH-CORE Operating Rules
- EDI 101
- User Documentation

Acceptable Claim Formats
ASK accepts and edits electronic claims submissions using the following formats:
- ANSI X12 837P 5010 based on the HIPAA Implementation Guides (Professional)
- ANSI X12 837I 5010 based on the HIPAA Implementation Guides (Institutional)

Providers receive a clearinghouse response report for each electronic submission that indicates:
- Whether we have received the file
• The number of claims submitted successfully
• The data fields that need to be corrected before electronically resubmitting a claim returned for edit errors

Changes in Claims Routing Services
Medicare Primary Claims Routing
In the past, we have routed Medicare Primary claims as a courtesy. This service is no longer available when submitting claims to our clearinghouse.

Please contact Medicare’s Electronic Media Communications Department, at 1-607-766-6000, as soon as possible to set up your system for direct submission of these claims to Medicare.

Other Payer Claims Routing
When you enroll with ASK, you will be offered a one-year free trial membership to ASK’s commercial clearinghouse, EDI Midwest. This offer provides you with the option of clearing other payers’ claims through ASK. EDI Midwest routes claims to 800 payers around the nation.

EDI Midwest will only accept claims that can be sent to their final destination electronically. Your ASK EDI Account Representative can give you more detailed information about EDI Midwest at the time you enroll to submit your claims to ASK. You can contact ASK directly at 1-800-472-6481.

If you elect not to use the services of EDI Midwest, please make arrangements with your current clearinghouse vendor or submitter to have non-BlueCross BlueShield claims submitted directly to the appropriate payer.

We will continue to process claims destined for our vendors and all of our lines of business including: Non Direct-Bill ITS/BlueCard, Express Scripts, and Federal Employee Program (FEP).

Non-Electronic Claim Forms
Non-electronic claims should be submitted using the approved CMS-1500 or UB-04 claim form. Please note that all required fields of the claim form must be completed, or the claim may be returned for additional information. These forms can be purchased from your forms vendor.

National Provider Identifier (NPI)
We require the submission of the provider's Billing NPI number and not the 12-digit provider number on the claim form.

Mail all claims, (Local, Indemnity, and Managed Care, including Senior Blue HMO and BlueSaver plans), to:
BlueCross BlueShield of Western New York
P.O. Box 80
Buffalo, New York 14240-0080
Federal Employee Program (FEP):
BlueCross BlueShield of Western New York
Attention: FEP Department
P.O. Box 80
Buffalo, New York 14240-0080

To improve accuracy and timeliness of paper claim submissions, we utilize Optical Character Recognition/Intelligent Character Recognition (OCR/ICR). To maximize the efficiency of this technology, we are asking providers who submit paper claims to use the red CMS 1500 (2-12) or UB-04 standard claim forms.

Claim Submission Tips
- Use the red CMS 1500 or UB-04 claim forms.
- Check your printer to ensure that your ink is dark.
- Do not highlight data on the claim form.
- Check your printer to ensure that it is lined up with the fields on the claim form.
- If the information submitted is incorrect or missing, we may generate a letter asking you to resubmit the claim with the correct information.
- The use of any other type of CMS1500 or UB-04 claim forms other than the red forms will delay processing.
- Paper claims must have a physical address in box 33; if a PO Box is submitted, the claim will be returned for correction and resubmission.
- ZIP codes must be submitted with 9 digits

Timely Filing

As of April 1, 2010, all claims must be submitted to BlueCross BlueShield within 120 days from the date of service. Claims that are submitted after 120 days will be denied. The calculation begins from the date of service, discharge date or last date of treatment up to 120 days, including weekends. Do not delay the billing of a claim for any reason.

If a claim denies for timely filing and you have previously submitted the claim within 120 days, resubmit the claim and denial with your appeal. Listed below are the guidelines for submitting appeals.

Timely Filing Does Not Apply To:
- Early Intervention Providers
- National Accounts
- HMO USA
- Vision Contracts
- Medicare Secondary Claims
- Workers Compensation
Submitting Appeals
Submit all timely filing appeal requests in writing, stating the reason for the delay of submission beyond 120 days. The claims you are appealing must be on paper and attached to your appeal. Please keep copies of the information you send for ease in identifying claims that will be approved/denied.

Electronically Submitted Claims:
For electronic claims that have not been processed, please submit one of the following reports with your appeal request and claim(s):

- Deleted Claim Edit Report
- Clearinghouse Response files

If you would prefer to receive these reports instead of your vendor, please contact ASK at 1-800-472-6481.

If you are using the electronic response file to do automatic posting of errors or claims accepted, the following information needs to be included on the report you send to us:

- Error record
- Record sequence
- Error code
- Clearinghouse messages
- Error field
- Error description

Continue to balance your submission counts to those on the Clearinghouse Response file. If a discrepancy exists between the counts, notify our Help Desk immediately. The Clearinghouse Response file will be the only notification you will receive about a claim deleted in the transmission.

If you currently do not receive any of the above reports or experience discrepancies on claim counts, contact ASK at 1-800-472-6481.

Clearinghouse Rejections
If a claim rejects in the clearinghouse (i.e., invalid member identification number), submit your deleted claim edit report and claim with your appeal.

Coordination of Benefits (COB)
If an insurance carrier other than BlueCross BlueShield is the primary carrier, then providers must submit the other carrier's payment voucher and claim within three months of the payment from the other carrier. COB claims can be submitted using the 837I or 837P. Providers do not need to submit the other carrier explanation of benefits (EOB) if all of the information is submitted on the 837.
If a provider is receiving an 835 (electronic remittance), they may or may not have a paper voucher or EOB to submit to BlueCross BlueShield. The information received on the 835 should be incorporated into the secondary fields on the 837.

Incorrect Insurance Information
If the member provided incorrect insurance information, the denial notice from the other carrier must be submitted with the original claim within three months of the other carrier's denial.

No Coverage
If a participating provider, in dealing with a patient finds that he/she has no insurance, the member should be asked to sign and date a patient responsibility form or waiver. A provider may seek payment from the patient for any services provided. If the member realizes that he or she has BlueCross BlueShield coverage after a provider has billed the member and the claim is beyond the three month timely filing limit, the provider should submit the signed waiver/patient responsibility form and claim with your appeal. Do not re-bill the member.

If you do not have a signed waiver, submit copies of billing statements with your claim(s) and appeal that indicates that you have billed the member who has now advised you that he/she has BlueCross BlueShield insurance.

Member Held Harmless
Participating providers are responsible to abide by the stipulations of the BlueCross BlueShield provider agreements. In cases where services were not billed to us within the timely filing limits, you cannot bill the member directly. The member is to be held harmless. The reimbursement issue is between you as a participating provider and us as the insurer. You may file the claim late with a request to waive the limit with an explanation. Upon review of your appeal, approval or denial will be determined. However, at no time is the member to be held responsible.

Filing Requirements for Members and Non-Participating Providers
Claims submitted by members or non-participating providers (for traditional and approved services through our managed care contracts) must be submitted within the following time frames:

- Dental: 24 months
- Major Medical: 12 months
- Traditional: 12 months
- Managed Care: 12 months

If claims, requests for adjustments, appeals or claim reviews are submitted by the member or a non-participating provider after the above time frames, the claim will be denied. The non-participating provider can bill the member for these denied claims.
Claim Adjustment Policy

Effective January 1, 2005, BlueCross BlueShield of Western New York implemented a standard claim adjustment policy for all providers.

BlueCross BlueShield will accept claim adjustment requests up to 180 days from the end of the calendar year in which the claim in question was adjudicated. Adjustment requests received after that time frame has expired will not be processed.

Additionally, BlueCross BlueShield will not initiate any retroactive claim adjustment activities after the 180-day timeframe has expired for paid claims.

Exclusions to this Policy

- Claims investigated as part of an internal audit for fraud, waste or abuse are exempt from this policy and are subject to payment recovery.

- Coordination of Benefits (COB) and Other Party Liability (OPL) situations are exempt from this policy. Consideration of claims/adjustments will be based on current COB/OPL timely filing guidelines. In the case of No Fault and Other Insurance situations, submissions and adjustment requests must be received within 120 days of the other carrier’s process date. Claims that are related to Workers’ Compensation are not subject to timely filing limitations.

Claims Submission for Medicare Supplemental Contracts Medicare Part B

Medicare Supplemental contracts are designed to accompany traditional Medicare coverage. Claims must be submitted to Medicare first for processing. Claims processed by the Upstate Medicare Part B Division with one or more lines approved to pay are sent to BlueCross BlueShield electronically on the Medicare Crossover Tape. BlueCross BlueShield processes the balance for members who have a Community Blue 65 Rider, Traditional Over 65 and Medigap coverage. Medicare balances are paid directly to our participating providers, regardless of whether or not the provider accepts assignment with Medicare. Payment is sent to the member if the provider rendering the service does not participate with BlueCross BlueShield.

Auto/National Accounts Exception

The exception to the above is for members that have coverage through our Auto/National contracts. We will continue to reimburse providers based on their participation with Medicare for these members. If you participate with Medicare, your covered balances will be sent directly to you from BlueCross BlueShield. If yes (EOMB)

When a Medicare Part B claim is transferred to BlueCross BlueShield for processing, the Explanation of Medicare Benefits (EOMB) will state: “This claim has been forwarded to the appropriate complementary insurer.” If this message appears, do not submit a paper claim to us. However, if this message does not appear and the patient is covered
by Community Blue 65 Rider, Traditional Over 65 or Medigap, send us a completed, approved claim form

If the claim does not electronically transfer to BlueCross BlueShield, this may indicate that the Medicare Identification Number on our files does not match the number on Medicare's files. To assure that claims for this patient are electronically transferred in the future, notify our Customer Service Department so we can investigate and update our membership files. Claims that are not electronically transferred to BlueCross BlueShield can be submitted electronically or by paper.

Medicare Part B claims can be submitted using the 837I or 837P. Providers do not need to submit the EOMB if all of the information is submitted on the 837. If a provider is receiving an 835 (electronic remittance), they may or may not have a paper voucher or EOMB to submit to BlueCross BlueShield. The information received on the 835 should be incorporated into the secondary fields on the 837.

Please submit claims only if they have not been transferred to us on the crossover tape to:

BlueCross BlueShield of Western New York
P.O. Box 80
Buffalo, New York 14240-0080

**New York State Prompt Pay Interest**
Prompt Pay Interest exceeding $1.99 per claim is generated on a daily basis for claims not processed within 30 days of BlueCross BlueShield's receipt of the claim. Checks and wire payments are issued more frequently than the weekly cycle to ensure that prompt pay requirements are met. Any interest paid appears under the "Interest Paid" column on your payment voucher.

Claims submitted for adjustment due to errors caused by BlueCross BlueShield processing receive prompt pay interest.

The following are excluded from prompt pay interest:

- Administrative Services Only (ASO) & Administrative Services for National Accounts (NSO) contracts
- Federal Employee Plan (FEP) contracts
- Services rendered by out-of-state providers
- Senior Blue and BlueSaver claims from non-participating providers
- National Accounts, when an out-of-state Plan, is the control Plan
- Blue Card claims for Members from Plans outside New York State, home and host

If you are a capitated provider billing for fee-for-service procedures, prompt pay interest will be calculated for those claims, if necessary.
Coordination of Benefits (COB)
Coordination of benefits applies to members who have more than one group health insurance contract. BlueCross BlueShield coordinates benefit payments with other carriers to ensure members receive all of the benefits to which they are entitled and to prevent duplicate payments. Other insurance information should be verified each time that a patient visits your office.

Preauthorization and Referral Requirements
For managed care (including POS in-network claims), all preauthorization/referral policies and procedures apply, even though BlueCross BlueShield may be the secondary payor.

For Preferred Provider Organization (PPO) contracts, all preauthorization policies and procedures apply, even though BlueCross BlueShield may be the secondary payor.

Preauthorization is not required for patients with Medicare as their primary insurance.

If appropriate preauthorization of services has not been made, or if a valid referral has not been issued before processing a claim, we may deny payment even on a secondary basis if the services are determined not to be medically necessary.

Primacy
When a patient is covered by two or more health insurance plans, one plan is determined to be primary and its benefits are applied to the claim. The following rules apply when determining which carrier is primary:

1. If one policy does not have a COB provision, then it will be primary.
2. If the patient is covered under one policy as the employee and under another policy as a dependent, the policy which covers the patient as an employee will be primary.
3. The primary policy for children is the policy of the parent whose birthday (month and day) falls earlier in the year. If both parents have the same birthday, the policy that covered the parent longer is primary.
4. When there is more than one insurance policy and the parents are divorced or separated, the rules of primacy vary depending on the court decision.
5. If the patient is the policy holder and covered under one of the policies as an active employee, neither laid off nor retired, and also covered under another policy as a laid off or retired employee, the policy covering the patient as an active employee will be primary.
6. If none of the above applies, then the policy that has covered the patient for the longest time will be primary.

Submitting Claims for Secondary Reimbursement
Claims must be submitted on paper, using a CMS 1500 or electronically on the 837I or 837P. All line items billed to the primary carrier should be submitted on the secondary claim.
Attach a copy of the primary carrier’s Explanation of Benefits Statement and indicate balance due. The balance due is the amount to be considered by BlueCross BlueShield or the patient's responsibility.

Attach a copy of the primary carrier’s Explanation of Benefits Statement. Claims submitted on paper without the Explanation of Benefits Statement, will be rejected.

Managed Care Claims
When a claim for managed care (including POS in-network) services is secondary, the benefits of the member’s BlueCross BlueShield contract will be reduced so that the total benefits payable under the other policy and under the contract we provide to the member do not exceed the amount we would have paid if we were primary.

Traditional Claims
When a claim for Traditional, PPO or POS out-of-network services is secondary, our payment will not exceed our allowance for the services. Also, the sum of the primary and secondary payments will not exceed the provider's charge.

Bill Your Usual Charge
Regardless of our allowance for a service, you should always bill your usual charge. This is beneficial in several ways:

1. It enables us to determine average charges for procedures.
2. By using one charge to bill all insurance companies, the chance of billing errors is reduced.
3. If more than one insurance company has liability for a claim, your standard charge eliminates confusion and helps to ensure proper payment.
4. **Professional Courtesy** - No reimbursement will be provided to a provider billing for professional services rendered to his/her immediate family, regardless of whether the family member has coverage under a BlueCross BlueShield contract. Immediate family is defined as the provider’s spouse, children, parents and siblings. BlueCross BlueShield will not reimburse for services that would normally have been furnished without charge

Payment Voucher
Payment vouchers include a detailed explanation of each claim by line of service. Electronic vouchers are available via a web application by enrolling for this service at Payspanhealth.com. Participating provider summary checks are distributed weekly. Summary checks include payment for claims that finalize during the week's processing. Additional checks will be issued on a daily basis to ensure prompt pay requirements are met.

Electronic transfer of funds is also available by enrolling for this service at Payspanhealth.com. Checks are attached to a simplified summary statement which identifies the total number of claims processed, total services processed and paid, adjustments, and withdrawn payments.
Enrollment in our electronic voucher is mandatory for all providers and EFT payment programs is mandatory for all facility providers. BlueCross BlueShield has implemented HIPAA compliant Claim Adjustment Reason Codes per the HIPAA 835 Electronic Remittance Transaction standard. Placing the adjustment codes as the first characters in the EX code description will also allow providers to cross-reference electronic remittance with their paper vouchers.

The complete list of Claim Adjustment Reason Codes can be found at the Department of Health and Human Services website.

**Claim Inquiries and Adjustments**

**Provider Claim Inquiry Form**
The Electronic Provider Inquiry (EPRO) via HEALTHeNET or the Provider Claim Inquiry Form should be used to submit provider appeals, inquiries and adjustment requests for all BlueCross BlueShield lines of business. Adjustment requests should be submitted within 180 days from the original claim process date. Instructions for use of the EPRO application are available on the HEALTHeNET website. The paper inquiry form and instructions for its use are available on our provider website.

**Coding Changes**
When requesting an adjustment to change a procedure code, please submit *with medical documentation substantiating the change*. Adjustments received without supporting documentation will be returned to the provider.

Billing with correct procedure and diagnosis codes not only promotes accurate and timely reimbursement, it also supplies critical data which is used to create provider profiles and establish practice patterns.

**Overpayments**
If your claim is overpaid, please request an adjustment by submitting a Provider Claim Inquiry Form and a copy of the payment voucher that lists the payment. The overpayment will be withdrawn from a future payment. Please do not refund any overpayment to us by check.

**Negative Balance**
A negative balance (or an accounts receivable, i.e., AR) is a financial balance that is unresolved and owed to BlueCross BlueShield as a result of a claim adjustment that has not yet been offset. A voucher reduction is not the same as a withdrawal from a bank account. If you do not have a payment to offset a down adjustment, this will result in a negative balance.

BlueCross BlueShield does not withdraw monies directly from bank accounts belonging to provider practices when negative balances occur.

**Examples of Overpayments:**
BlueCross BlueShield reviews claims for accuracy and requests refunds if claims are overpaid or paid in error. Providers also may identify overpayments and bring them to our attention. Some common causes of overpayments are:

- Post payment review
- Coordination of benefits
- Allowance of overpayments
- Rate adjustments
- Provider billed in error
- Duplicate claim submission
- Non-covered services
- Claims editing
- Changes in eligibility

**BlueCross BlueShield-identified negative balance:**
When refunding BlueCross BlueShield on a claim overpayment that we’ve requested, please return the negative balance request letter and ensure that this is included with your payment for prompt offset.

Providers and facilities may also request recoupment by transferring their negative balance to an active provider ID number and signing the “Request to Resolve Provider Negative Balance” form and faxing it to the number indicated on the form. (Note: this is a dedicated fax number for immediate recoupment notification and should not be used to submit disputes or any other inquiries.)

Providers and facilities direct disputes of amounts indicated on the negative balance request letter to the address indicated, or contact the phone number on the letter. Please note that the plan may recover the unresolved overpayment through remittance adjustment or other recovery action.

**Provider- and facility-identified overpayments (“unsolicited”):**
If BlueCross BlueShield is due a refund as a result of a negative balance and you have not yet been notified but would like to clear this balance, refunds can be made by completing and submitting a refund check with supporting documentation outlined below. You may also provide an active provider ID in which to transfer the negative balance by using the “Request to Resolve Provider Negative Balance” form (in Appendix 3 of this manual).

While submitting your refund, please include the following information:
- Provider ID
- Voucher date of negative balance
- Contact number of the provider’s office, in case there are any questions

**General reminders:**
If you carry forward a credit balance for 90 days, BlueCross BlueShield may send a letter requesting a refund to clear the credit balance.
BlueCross BlueShield may not be able to credit your remittance without sufficient information. When returning an overpayment, please use the “Request to Resolve Provider Negative Balance” form in Appendix 3 of this manual to ensure we appropriately apply your credit.

Provider Support Tools
BlueCross BlueShield has created a variety of tools to help the staff in providers’ offices understand our contract benefits, claim submission procedures and medical policies. Some of the tools available for your use are:

HEALTHeNET
wnyhealthecommunity.com is an online community health information network established by an independently incorporated coalition of health insurance plans, including BlueCross BlueShield of Western New York, and hospital providers.

The standard set of transactions available online are as follows:

- Eligibility Transaction (270/271)
The eligibility transaction gives offices a direct connection to membership files and allows providers to confirm patients’ eligibility in just minutes.

- Claim Status Transaction (276/277)
This feature allows you to check the status of your claims, eliminating the need to contact the Provider Service Department.

- Direct Access to Referrals (278)
This transaction will allow you to submit/inquire/update referrals for your patients.

Transactions created through the HEALTHeNET application constitute standard ANSI X12 transactions as defined and regulated by the HIPAA mandate (see 45 CFR Parts 160 and 162 - Standards for Electronic Transactions).

Electronic Provider Inquiry
This application allows users to submit inquiries electronically, including attachments. The payer will respond to these inquiries electronically as well.

To Sign Up:
- Open your Internet browser and go to wnyhealthenet.org
- Click on the 'Sign Up' tab at the top of the HEALTHeNET home page.
- Complete the online enrollment form. A representative will contact you within five business days of your request to provide further instructions and schedule training.

Provider Pending Claims Status Report
A weekly report identifies claims that we have received and are pending. The following codes are used within the report to identify claims status.
ADJ  Adjustment received, pending final disposition  
AMI  Claim received, awaiting additional medical information  
COB  Claim received, COB external information requested  
PFD  Claim received, pending final disposition  
RMN  Claim received, reviewing for medical necessity

Used in conjunction with your payment vouchers, this report enables you to determine if BlueCross BlueShield has received your claim. If a claim is not listed on the Status of Pending Claims Report or on your payment voucher within 30 days after submission, please submit a new claim electronically. Please do not write "rebill" or "resubmission" on paper claims since this will delay processing.

**Physician Patient Roster**

The BlueCross BlueShield Physician Patient Roster is available on our secure website. This is a monthly report to PCPs to help them identify which of their patients are managed care members and provides physicians with other valuable information including:

- Which patients have chosen them as their PCP
- Member copay and type of contract
- Member prefix and suffix

Physicians should use this list to verify patients who have selected them as their PCP.

**Coding and Modifiers**

Accurate and exact coding is required for appropriate reporting and processing of claims.

Modifiers identify situations inherent to a procedure. Use modifiers to ensure accurate claims processing.

Adhere to CPT and HCPCS coding guidelines when using modifiers to ensure accurate claims processing. Please refer to your CPT/HCPCS books for the most current codes and modifiers.

Tip for coding additional diagnosis (all chronic conditions):

Providers can use code 99080 (Special Reports) to submit additional claim lines with zero charges, if necessary, in order to accommodate the need to send additional diagnosis codes.

**Clinical Edits / Incidental Denials**

BlueCross BlueShield uses a vendor-supplied application within our claim processing system, ClaimsXten (CXT), to identify possible unbundled coding and incidental procedural relationships. ClaimsXten automatically analyzes all provider claims for appropriate billing. This includes editing the information submitted on a claim in relation to itself and other claims in a member’s claims history. ClaimsXten helps reduce post-payment audits and adjustments. The logic in the ClaimsXten application is based on
Current Procedural Terminology (CPT) and Healthcare Common Procedure Systems (HCPCS) coding guidelines (including the appropriate use of modifiers), analysis of standard medical and surgical practices including review of current coding practice and BlueCross BlueShield’s medical policies as well as, but not exclusively, Centers for Medicare and Medicaid Services (CMS) Procedure to Procedure (PTP) standards.

Line item denials on a claim with explanation codes that begin with a lower case letter (alpha), e.g., e31, fc2, are created by ClaimsXten (these translate to Claim Adjustment Reason Code 97 on an 835). Payment for these codes is subsumed by the payment for the codes to which they are considered incidental or into which they are bundled.

ClaimsXten also identifies “No Separate Fee” (NSF) codes. NSF codes are those considered incidental to/bundled with other reported codes and/or are not considered to add significant additional time, cost, or complexity to the other codes being reported. NSF logic helps reduce post-payment audits and adjustments. NSF logic is based on CPT and HCPCS coding guidelines (including the appropriate use of modifiers); analysis of standard medical and surgical practices including review of current coding practice; BlueCross BlueShield’s medical policies; and Medicare’s payment standards (i.e., status B codes, status P codes, status T codes).

NSF line item denials on a claim will appear with various explanation codes, with the most common being e26, g28, BK2 and MK2 (these translate to Claim Adjustment Reason Code 97 on an 835). Payment for these codes is subsumed by the payment for the codes to which they are considered incident/into which they are bundled.

All ClaimsXten and NSF edits are applied to claims after contract pricing is applied.

The ClaimsXten and NSF logic is updated at least quarterly to acknowledge any additions, deletions, and/or changes to guidelines, policies, and standards.

Clinical edits are available on our secure provider website using our Clear Claim Connection clinical edit search application. NSF edits are available on our secure provider website via the Code & Comment tool.

Routine Services for Qualifying Clinical Trials

Routine services for (or associated with) qualifying clinical trials are eligible for coverage. The standard edits will apply including, but not limited to: preauthorization, unbundling, investigational, and contract in effect at the time of service. The item, device, drug or service that is the focus of the trial is not covered and will be rejected as investigational if billed to BlueCross BlueShield of Western New York.

All Medicare Advantage (Senior Blue, BlueSaver and Medicare PPO claims related to clinical trials should be submitted to original Medicare. Only secondary balances should be submitted to BlueCross BlueShield, as these claims will not automatically cross over from Medicare.
Billing for Patients Participating in Clinical Trials
ICD-10 Diagnosis Requirement
List diagnosis code on each service related to the clinical trial to indicate the member is participating in a clinical trial. You must include all appropriate clinical trial codes and modifiers.

The following are the diagnosis codes to be used for submitting claims/authorizations:

<table>
<thead>
<tr>
<th>ICD10 effective Oct. 1, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z00.6 (Encounter for examination for normal comparison and control in clinical research program.)</td>
</tr>
</tbody>
</table>

HCPCS
S9988 services provided as part of a phase I clinical trial
S9990 services provided as part of a phase II clinical trial
S9991 services provided as part of a phase III clinical trial

One of the above HCPCS codes must be included as a one-line entry on each claim with $0.00 indicated for the charge. These codes are informational and not separately reimbursed.

Modifiers
One of the following modifiers needs to be indicated on each clinical trial service:

Q0 - Investigational clinical service provided in an approved clinical research study.
The Q0 modifier is used for the item, device, drug or service that is under investigation in the clinical trial or for services unique to the trial requirements, such as data collection.

Q1 - Routine clinical service provided in an approved clinical research study.
Routine services related to qualifying clinical trials submitted with a modifier have potential for coverage. However, if the modifier indicating the routine service is a part of a qualifying trial (Q1) is not documented, the service will be considered investigational as part of a non-qualifying trial, and therefore not eligible for payment.

Use of these modifiers attests to the services being performed in qualifying clinical trials.

Condition code 30 - Available for inpatient claims to indicate the admission includes qualifying trial services.

It is expected that we will not be billed for any services related to non-qualifying trials or for anything provided free of charge by trial sponsors.
Lesions
The CPT4 codes for lesion treatments include specific verbiage that needs to be considered in determining whether more than one unit of service or line of service can be billed for a code and if any other codes can be billed with it.

Listed below are the CPT4 codes and the maximum number of units that should be reported on a claim for a date of service.

<table>
<thead>
<tr>
<th>Code</th>
<th>Verbiage</th>
<th>Maximum Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>11055</td>
<td>Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion</td>
<td>01</td>
</tr>
<tr>
<td>11056</td>
<td>Two to four lesions</td>
<td>01</td>
</tr>
<tr>
<td>11057</td>
<td>More than four lesions</td>
<td>01</td>
</tr>
<tr>
<td>17000</td>
<td>Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), premalignant lesions (e.g., actinic keratoses); first lesion</td>
<td>01</td>
</tr>
<tr>
<td>17003</td>
<td>Second through 14\textsuperscript{th} lesion, each (list separately in addition to code for first lesion)</td>
<td>13</td>
</tr>
<tr>
<td>17004</td>
<td>Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), premalignant lesions (e.g., actinic keratoses), 15 or more lesions</td>
<td>01</td>
</tr>
<tr>
<td>17110</td>
<td>Destruction by any method of flat warts, molluscum contagiosum, or milia; up to 14 lesions</td>
<td>01</td>
</tr>
<tr>
<td>17111</td>
<td>15 or more lesions</td>
<td>01</td>
</tr>
<tr>
<td>• No more than one of the following codes can be reported for an encounter: 11055, 11056, 11057</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 17003 can only be billed with 17000. Do not report 17004 in conjunction with codes 17000 or 17003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Code 17111 cannot be reported with 17110</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mammography
Please be sure to use the appropriate CPT codes when billing mammography to differentiate diagnostic from screening.

Diagnostic codes should be used when the procedure is ordered because of a suspicion of breast disease (due to symptoms or clinical findings), patient history of breast cancer or biopsy proven breast disease.

Screening Mammography
A screening code should be used when the procedure is done as a baseline or on a routine basis.

Multiple, Bilateral, and Multiple Bilateral Procedures
Surgical:
In accordance with Current Procedural Terminology (CPT) guidelines, bilateral procedures should be billed on one line only, utilizing the modifier 50; enter one as 01 in the units field and bill your total bilateral charge.

Bilateral Billing Examples
• Bilateral breast reconstruction – report as code 19357 with modifier 50 on one claim line with 01 in the units field.

• Bilateral lower and upper blepharoplasties – report as:
  - 15820 with modifier 50 on the first claim line with 01 units
  - 15822 with modifier 50 on the second claim line with 01 units

Note: For bilateral services, do not bill modifier LT/RT or any other site-specific modifier other than 50.

Multiple Procedures
Separate billing is allowed for multiple procedures performed on the same day that add significant time or complexity and are not incidental or an integral part of the primary procedure. The primary procedure is reimbursed at the fee schedule amount; eligible secondary procedures are reimbursed at 50 percent.

Multiple procedures that involve the same service performed more than once (such as CPT code 26100, arthrotomy of each carpometacarpal joint of the left hand), should be billed as five separate lines on the claim form along with the modifier 59 or the HCPCS individual digit modifiers on lines two through five in order to clarify that the additional lines are definitely separate services.

Procedure code descriptions including more than one unit of service provided, (such as code 95117, professional services for allergy immunotherapy, two or more injections, or code 96406, intralesional injections, more than seven lesions), are reported on one line with only one (01) unit.
Final reimbursement is also determined after applying usual edits such as (but not limited to) preauthorization, cosmetic coverage and bundling. In addition, the member’s contract must be active at the time the service is rendered.

**Physician/Provider Exceptions** (Does not apply to Hospital category reimbursement)
When the CPT code description includes: "each additional" (for example, code 63048, laminectomy, each additional cervical, thoracic, or lumbar segment), **report the code on one line with the number of additional segments indicated in the units field.**

When the CPT code states: "specify number of tests, doses" (such as code 95024, intradermal tests with allergenic extracts), **report the code on one line with the number of tests, doses, etc., indicated in the units field.**

**Code & Comment**
The Code & Comment section on our provider website is an extremely valuable tool that, among other things, can help you determine if a surgical code is bilateral. The Code & Comment tool provides procedure code coverage information including preauthorization requirements and potential medical policies/protocols that may apply. Code & Comment is available as a "Quick Link" on our secure website. Once selected, a pop-up window will appear. Once you type in a procedure code and select a code type, the coverage information will be returned. A key is also available to explain the abbreviations used in the results. The key also describes some of the fields found in the tool and provides further explanation. The key should be consulted frequently as information can change.

**Non-Ionic Low Osmolality Contrast Media**
Contrast media will not be considered for separate payment and cannot be billed to the patient. Reimbursement for contrast media is included in the allowance for the radiology service. To maintain accurate records of the use of non-ionic contrast media, use the appropriate CPT/HCPCS code.

**Sleep Studies**
Modifier 26 (for the physician component/CMS 1500 or 837P claim) and modifier TC (for the hospital or technical services/UB04 or 837I claim) must be used when a sleep study is performed at a hospital or affiliated clinic.
<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Revenue Codes</th>
<th>Bill Type</th>
<th>CPT Codes</th>
<th>*Roll-Up/ Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgery</td>
<td>0360-0361, 0490, 0750 &amp; 0790</td>
<td>131</td>
<td>YES</td>
<td>Yes / Category and contract may allow for additional reimbursement of eligible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Valid Category</td>
<td>implantable prosthetic devices (revenue codes 274 &amp; 278), pacemakers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CPT Code Required</td>
<td>(revenue code 275). Eligible secondary procedures pay at 50 Percent.</td>
</tr>
<tr>
<td>1a Cancelled Ambulatory Surgery</td>
<td>0360-0361, 0490, 0750 &amp; 0790</td>
<td>131</td>
<td>YES</td>
<td>Bill Claim with Occurrence Code 43. Reimbursement based on record review or use</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Valid Category</td>
<td>modifier 53</td>
</tr>
<tr>
<td>2 Emergency Room / &quot;Urgent Care&quot;</td>
<td>0450, 0459</td>
<td>13X</td>
<td>YES</td>
<td>YES/ Case Rate</td>
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<tr>
<td>Service within Emergency Department</td>
<td></td>
<td></td>
<td>Valid Category</td>
<td></td>
</tr>
<tr>
<td>2a ER Physician Fee</td>
<td>0981 (For hospital employed MD's only)</td>
<td>13X</td>
<td>YES</td>
<td>NO/ Fee Schedule</td>
</tr>
<tr>
<td>3 Observation</td>
<td>0762</td>
<td>13X</td>
<td>NO</td>
<td>Per diem/Per Case, pays in addition to ER</td>
</tr>
<tr>
<td>4 Urgent Care Centers</td>
<td>456</td>
<td>89X / 13X</td>
<td>YES</td>
<td>YES/ All-inclusive case rate (fee schedule)</td>
</tr>
<tr>
<td>5 Clinic</td>
<td>Must be billed on a HCFA1500/ANSI837 Professional Form.</td>
<td>N/A</td>
<td>YES</td>
<td>NA / Follows physician reimbursement guidelines. TC split for Medicare</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Codes</td>
<td>Column 1</td>
<td>Column 2</td>
</tr>
<tr>
<td>---</td>
<td>-------------</td>
<td>-------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>6</td>
<td>Chemotherapy*</td>
<td>0280-0289, 0331, 0332, 0335</td>
<td>13X</td>
<td>NO</td>
</tr>
<tr>
<td>7</td>
<td>Radiation Therapy</td>
<td>0330, 0333, 0339</td>
<td>13X</td>
<td>YES</td>
</tr>
<tr>
<td>8</td>
<td>Transfusion*</td>
<td>0390, 0391</td>
<td>13X</td>
<td>YES - 391 36430-36460</td>
</tr>
<tr>
<td>9</td>
<td>Home Infusion Therapy</td>
<td>0640 - 0649</td>
<td>33X 34X</td>
<td>YES</td>
</tr>
<tr>
<td>9</td>
<td>Cast Room*</td>
<td>0700, 0709</td>
<td>131</td>
<td>NO</td>
</tr>
<tr>
<td>10</td>
<td>Infusion Therapy*</td>
<td>0260-0269</td>
<td>131</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>---</td>
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<td>---</td>
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<tr>
<td>11</td>
<td>Dialysis</td>
<td>0820, 0821, 0830, 0831, 0840, 0841, 0849, 0850, 0851, 0859</td>
<td>13X 72X</td>
<td>YES, per contract</td>
</tr>
<tr>
<td>12</td>
<td>Epogen</td>
<td>0634-0635</td>
<td>13X 72X</td>
<td>YES</td>
</tr>
<tr>
<td>14</td>
<td>False Labor</td>
<td>0720 - 0729</td>
<td>13X</td>
<td>NO</td>
</tr>
<tr>
<td>15</td>
<td>Recovery Room</td>
<td>0710 - 0719</td>
<td>13X</td>
<td>NO</td>
</tr>
<tr>
<td>16</td>
<td>Ambulance</td>
<td>0540 - 0549</td>
<td>131</td>
<td>N/A</td>
</tr>
<tr>
<td>17</td>
<td>Cardiac Rehab</td>
<td>0943</td>
<td>131</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Category</td>
<td>Codes</td>
<td>YES Code</td>
<td>YES</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------</td>
<td>-----</td>
</tr>
<tr>
<td>18</td>
<td>Diagnostic Testing</td>
<td>0300-0309, 0310-0319, 0340-0349, 0350-0359, 0400-0409, 0460-0469, 0470-0479, 0480, 0482, 0489, 0610-0619, 0621-0622, 0720, 0730-0739, 0740-0749, 0920-0929</td>
<td>131</td>
<td>YES</td>
</tr>
<tr>
<td>21</td>
<td>Durable Medical Equipment (DME)</td>
<td>0290 - 0293, 0299, 0946, 0947</td>
<td>13X</td>
<td>YES</td>
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<tr>
<td>19</td>
<td>Electric Shock Psych / Other</td>
<td>0900, 0901, 0902, 0919</td>
<td>13X</td>
<td>YES</td>
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<tr>
<td>20</td>
<td>OP/Alcohol/Drug</td>
<td>0905, 0912, 0914, 0915, 0916, 0944, 0945</td>
<td>13X</td>
<td>YES</td>
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<tr>
<td>21</td>
<td>Therapies PT, OT, ST</td>
<td>0420-0429, 0430-0439, 0440-0449, 0530-0539, 0940-0941, 0949</td>
<td>13X</td>
<td>YES</td>
</tr>
<tr>
<td>22</td>
<td>Fetal Non-Stress</td>
<td>0720</td>
<td>131</td>
<td>YES</td>
</tr>
<tr>
<td>23</td>
<td>Hospice</td>
<td>065X</td>
<td>81X 82X</td>
<td>N/A</td>
</tr>
<tr>
<td>24</td>
<td>Home Health Care</td>
<td>055X, 056X, 057X, 042X, 043X, 044X</td>
<td>33X 34X</td>
<td>N/A</td>
</tr>
<tr>
<td>25</td>
<td>Prosthetics and Implantables</td>
<td>0274, 0278, 0275</td>
<td>13X</td>
<td>HCPCS</td>
</tr>
</tbody>
</table>
0276 Intraocular lenses are included in a category 6 or 8 surgery.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Treatment Room*</td>
<td>0760, 0761</td>
<td>13X</td>
</tr>
<tr>
<td>27</td>
<td>Inhalation Therapy</td>
<td>0410 - 0419</td>
<td>131</td>
</tr>
<tr>
<td>28</td>
<td>High-Cost Drugs</td>
<td>0636</td>
<td>131</td>
</tr>
<tr>
<td>29</td>
<td>Supplies</td>
<td>0270, 0271, 0272, 0273, 0277 &amp; 0279</td>
<td>131</td>
</tr>
<tr>
<td>30</td>
<td>Miscellaneous Pharmaceuticals</td>
<td>0250-0259</td>
<td>131</td>
</tr>
<tr>
<td>31</td>
<td>Sleep Studies/Polysomnography</td>
<td>0740, 0920</td>
<td>131</td>
</tr>
<tr>
<td>32</td>
<td>Lithotripsy</td>
<td>360, 490, 790</td>
<td>131</td>
</tr>
</tbody>
</table>

The policies and procedures referenced in this section represent our standard for claims submission, payment, and adjustment. Certain providers may be subject to different guidelines due to contractual limitation or expansions.

* Service could pay up to $50 per day for room charge
Section 14 - Provider Reimbursement and Incentives

The following reimbursement methodologies are used by BlueCross BlueShield for the various contracts we administer. The contract language will determine which method is applicable. Contract language will also determine whether full payment or a percentage of payment is applicable.

Fee Schedules

The commercial managed care and traditional/indemnity fee schedules are based upon the Medicare Fee Schedule, which is derived from the Resource Based Relative Value System (RBRVS).

RBRVS methodology is used to price professional procedure codes based on the relative cost to provide a service. It consists of three components: relative value units, geographic adjusters and conversion factor. This reimbursement method was developed for CMS (Centers for Medicare and Medicaid Services) and implemented by Medicare in 1992. BlueCross BlueShield adopted a modified version of this method to establish a fee schedule and schedules of allowance. Yearly CPT code updates will be added.

The relative value unit has three components: total work of physician, practice expense such as office rent, salaries of office staff and supplies, and professional malpractice liability premiums. The geographic adjusters are applied to each of the relative value unit components to reflect how practice costs vary from locale to locale. The total of these adjusters then equals the total weighted relative value unit. The conversion factor is the dollar amount for one total relative value unit. Payments under RBRVS methodology are based on multiplying conversion factor by the total weighted relative value unit.

RBRVS is used to reimburse providers who participate with BlueCross BlueShield.

Exceptions to RBRVS payment under our HMO products include capitation arrangements, physical therapy services and laboratory services. Exceptions under our products include chiropractic services, laboratory services and Major Medical Alternative/Additional Benefits Riders.

Capitation

Capitation is a payment method based on a fixed dollar amount paid to a provider in advance, regardless of the number of services he or she provides. The lump sum payment is set on a per member per month basis.

Flat Rate Payment

This method of payment may be used for specific services clearly defined in certain contract language. For example, a Major Medical Rider may reimburse $50.00 for a routine physical exam.
Managed Care Fee Schedule
Participating providers are reimbursed according to our BlueCross BlueShield fee schedule for the following contracts:

- HMO 100 Series
- HMO 200 Series
- Healthy New York 201
- Traditional POS 200 Series
- Traditional PPO 800 Series
- Traditional 900 Series

Covered Services
Under the terms of our standard participating provider agreement, providers should always charge our members the negotiated rate for any covered services provided. This includes any situation where a member has reached the policy maximum and is paying for services without reimbursement. Under our agreement, a provider accepts that if the medical service they are providing is a covered service, they will accept the negotiated rate. If a service is a covered service, our members should never need to pay more than the negotiated rate plus cost share. Please see Section 4.1.2 of our standard agreement.

Anesthesia Services (Surgical or Maternity)
The administration of anesthesia by an anesthesiologist or CRNA in connection with covered surgery or maternity care is a benefit if the nature of the procedure requires anesthesia. Global surgery rules include that the physician performing an operation is responsible for treating postoperative pain. Anesthesia services, including postoperative pain management, provided by the operating surgeon, assistant surgeon or physician providing maternity care are not eligible for separate payment.

Effective October 1, 2015, anesthesia services should be billed under the rendering providers NPI using CPT code range 00100 – 01999. Anesthesia modifiers are required, and claims without the appropriate modifier will be returned. We will be recognizing all modifiers listed below, including services for the supervision of CRNAs.

AA – Anesthesia services performed personally by anesthesiologist
QZ – CRNA without medical direction by a physician
QX – CRNA with medical direction by a physician
QY – Medical direction of one CRNA by an anesthesiologist
QK – Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
AD – Medical direction of more than four concurrent anesthesia procedures
GC – This service has been performed in part by a resident under the direction of a teaching physician

Providers billing for the supervision of a CRNA should submit the appropriate CRNA and MD claims with the appropriate modifiers. Both claims should reflect the full charged amount and not show a reduction. During claim processing, our system will apply a reduction to each and pay each claim at 50% of the allowed amount.
Claims with an AA or QZ modifier indicate that no supervision occurred and will be reimbursed at the appropriate full allowed amount. Claims for services provided by residents should be submitted under the supervising physician with a modifier GC and will be reimbursed at the full allowed amount.

Effective January 1, 2016, postoperative nerve blocks for pain management performed by the surgical anesthesiology provider will be paid in addition to the surgical anesthesia

- Preauthorization and/or medical record documentation is not required.
- Modifier 59 is required on the nerve block pain management CPT code when billed for the same date of service as the surgical anesthesia.

Post-operative Pain Management
When billing for surgical anesthesia (00 services CPT codes) and for post-operative pain management, the codes must appear on the same claim. If billed separately, the claim for the post-operative pain management will be denied due to no preauthorization being on file.

The global operative anesthesia allowance payable to the anesthesiologist includes payment for all components that are considered an integral part of the anesthesia service. The following are not eligible for separate payment and the member cannot be billed:

1. Pre-anesthesia evaluation, including when surgery has been delayed and the pre-anesthesia evaluation was already done Note: A pre-anesthesia evaluation by the anesthesiologist where surgery is cancelled is eligible for coverage at the level of care rendered as hospital or office evaluation and management service
2. Post-operative visits
3. Anesthetic or analgesic administration including nerve blocks and continuous or single epidural, caudal, spinal, auxiliary, etc., injections for the purpose of administering the operative anesthesia
4. All necessary monitoring (i.e. IV, cardiac output measurements, blood gas interpretations, oximetry)
5. Intra-operative administration of drugs, IV fluids, blood, etc.
6. Hypothermia and/or pump oxygenator
7. CPT physical status modifiers or qualifying circumstances
8. Supervision of patient-controlled analgesia (PCA)
9. The administration of simple infiltration local anesthetic anesthesia (this is considered part of the global surgery allowance)

Separate payment to an anesthesiologist may be available for the following procedures done in conjunction with anesthesia:
- Emergency intubation during the surgical or maternity procedure where there is supporting documentation of an emergency situation
- Swan-Ganz insertion
- Critical care services unrelated to the surgical or maternity anesthesia service that require the physician's constant attendance
- Arterial line insertion
CVP line insertion

Other Anesthesia Services:

- Continuous epidural pain management during labor or the post-operative period is a separately payable service when it is medically indicated up to a five hour time period.
- An epidural catheter inserted for the sole purpose of pain management in addition to the anesthesia service for the surgery or delivery is eligible for separate payment. Reimbursement on the initial day is by the allowance for the catheter insertion and injection of anesthetic substance procedure code. After that, daily management provided by the anesthesiologist or CRNA is allowed for a reasonable period of time during the post-operative period.
- Patient controlled analgesia (PCA) is monitored by the nursing staff under the physician's direction. There is no separate reimbursement as it is considered part of the post-operative care covered under the global surgical fee.
- Anesthesia attendance or monitored anesthesia care (MAC) is eligible for coverage. For a procedure to be considered attendance and not stand-by, all of the following must be true:
  - The service was requested by the attending physician;
  - The anesthesiologist documented that he or she was present for the entire procedure and provided all the usual services, except actual administration of anesthetic agent; and
  - It was medically necessary for the patient's condition.
- For services when anesthesia isn’t recognized as appropriate in Code & Comment, preauthorization must be obtained.
- Non-routine anesthesia associated with surgery requires medical record documentation for reimbursement. Anesthesia administration is not normally required for non-surgical or dental procedures.

The following are non-covered services:

- Local anesthesia for dental services or anesthesia rendered by the dentist or other physician such as conscious or moderate sedation in his/her office
- Stand-by anesthesia
- Anesthesia by acupuncture or hypnosis

Operative anesthesia payments are determined by adding base units and time units, then multiplying the sum by the anesthesia factor rate.

\[(\text{Base Units} + \text{Time Units}) \times (\text{Anesthesia Factor Rate}) = \text{Payment}\]

Time units are based on the length of time required to prepare the patient for anesthesia in the operating room (or equivalent area), administer anesthesia, and through the time when the anesthesiologist's constant personal attendance was no longer required. Time should be indicated as total minutes on the claim.

One time unit is equivalent to fifteen minutes. When calculating time units, rounding can occur.
8 minutes or more - round up
Less than 8 minutes - round down

For example:  
1 hour and 7 minutes = 4 time units
1 hour and 9 minutes = 5 time units

Epidural During Labor  
(01967)  
The reimbursement for epidural pain management during labor is determined by a base unit and a time unit with associated dollar allowances for each. Payment is capped at a maximum of 20 time units.

Assistance at Surgery  
Payment will be made at 20 percent for physicians and 10 percent for physician assistants of our fee schedule. All services must warrant an assistant and be medically necessary. The member cannot be billed for denied services.

Physical and Occupational Therapy  
Providers will be reimbursed using an all-inclusive session fee, not by individual modality or procedure, for one therapy session/encounter per day.

Telehealth Services  
Telehealth is now a covered service, effective January 1, 2016. Preauthorization is not required. Place of service “02” and GT modifier are appropriate when billing for telehealth services. All services are subject to the member’s contract benefits and should be verified prior to providing services. Please visit the “code and comment” section of our website (log-in required) for more information about proper coding.

Reimbursement for Mid-Level Practitioners  

Physician Assistants and Nurse Practitioners  
The mid-level practitioner performing the service should bill under his or her own name and provider number. No additional claims for supervision should be submitted by other providers.

Physician assistants and nurse practitioners are reimbursed 80 percent of the appropriate fee schedule minus any applicable copays and/or coinsurance for: Office, home, hospital visits, nursing home visits and periodic exams.

Nurse Midwives  
Payment will be made at 80 percent of the appropriate fee schedule for professional services minus any applicable copays and/or coinsurance.
Follow-up Days
Follow-up days are the number of days anticipated for the recovery period for a surgical procedure. Any services provided relative to the same condition will not be covered if performed in the specified number of days. Our payment for these services is included in the initial surgical allowance. No additional benefits will be available in the follow-up period. Follow-up days are the same as Medicare’s, except for maternity procedures.

Health Care Provider Performance Evaluation
BlueCross BlueShield maintains a comprehensive Quality Management program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. Members and providers have opportunities to make recommendations for areas of improvement. The Quality Management program goals and outcomes are available to providers and members upon request.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the plan’s specific population occurs on an annual basis. This includes not only age/sex distribution but also a review of utilization data — inpatient, emergent/urgent care and office visits by type, cost and volume. This information is used to define areas that are high volume or that are problem prone. Studies are planned across the continuum of care and service, with ongoing proactive evaluation and refinement of health plan programs and initiatives.

Use of Performance Data
Practitioners and providers must allow BlueCross BlueShield to use performance data in cooperation with our quality improvement program and activities. Practitioner/provider performance data refers to compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual health care practitioner (such as a physician) or a health care organization (such as a hospital). Common examples of performance data include the HEDIS quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF).

Quality of Care
All physicians, advanced registered nurse practitioners and physician assistants are evaluated for compliance with pre-established standards as described in our credentialing program.
Review standards are based on medical community standards, external regulatory and accrediting agencies’ requirements and contractual compliance.

Reviews are accomplished by Health Care Quality Improvement (HCQI) team and health plan professionals who strive to develop relationships with providers and hospitals that will positively impact the quality of care and services provided to our members. Results are then submitted to our HCQI department and incorporated into a data summary.
Our quality program includes review of quality of care issues identified for all care settings. HCQI staff use member complaints, reported adverse events and other information to evaluate the quality of service and care provided to our members.

**Provider Profiling**

BlueCross BlueShield uses provider-profiling methodology, rationale and processes for evaluating physician performance. The method may include the following key measures: access and availability to care, member complaints, ER utilization, compliance with quality metrics, cost efficiency.

The principal features of the methodology ensure:

- Clearly defined goals and objectives for the profiling activity have been developed, including the communication of a profiling summary to providers and the provision of provider/office manager education, based on findings and corrective action plans with time tables and measurable benchmarks of success, as indicated.
- Descriptions and rationale for each measure have been developed, and supporting clinical documentation is included, when appropriate.
- A health care plan shall develop and implement policies and procedures to ensure that health care professionals are regularly informed of information maintained by the health care plan to evaluate the performance or practice of the health care professional. The health care plan shall consult with health care professionals in developing methodologies to collect and analyze health care professional profiling data. Health care plans shall provide any such information and profiling data and analysis to health care professionals. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. Any profiling data used to evaluate the performance or practice of a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the health care professional's profile and to work cooperatively with the health care plan to improve performance.
- Practice performance profiles examine a broad range of practice measures and have some adjustments for risk, and similar cohorts are analyzed across practices to fairly compare each provider.
- Profiles include data from multiple sources, including claims, HEDIS, medical record review data, utilization management and pharmacy data, member satisfaction surveys, enrollment and PCP assignment data, member complaints and provider-supplied information, such as office hours, walk-in policies, etc.

**Pay for Performance Program**

BlueCross BlueShield's Pay for Performance Program (P4P) was redesigned and implemented in 2009. It continues to encourage both quality and efficient delivery of care. The program was enhanced to improve the timeliness of reporting to physicians.
and address practice patterns, variations in care, and improve patient outcomes. As the program evolves, you will receive notice of any changes occurring in 2019 when applicable.

**Objectives**

- To reward physicians for the provision of quality care to our members
- Provide physicians timely reporting on performance
- Evaluate physicians on an individual basis
- Provide actionable reporting on P4P measures and non-compliant members
- To align with corporate strategic goals

BlueCross BlueShield has partnered with Vatica to offer a web-based tool to educate providers on ICD-10 coding accuracy. Practices will receive $150 for every Annual Wellness Visit performed with the Vatica tool. Please contact your practice account manager for more information.

**Program Design**

**Clinical Quality**

- Clinical quality measurement score goals (targets) may vary on an annual basis. The Pay for Performance team will establish annual targets using a blended average of plan performance and HEDIS benchmarks. Clinical quality scores will be pulled from Risk Manager™ and HEDIS definitions will be used.
- Providers who do not have an office in an eligible county are excluded.

Effective May 1, 2015, BlueCross BlueShield introduced an outcome-based performance opportunity to our 2015 physician performance quality initiatives. We have added the following CPT Category II codes for incentive:

<table>
<thead>
<tr>
<th>CPT II Code</th>
<th>Rate</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3044F</td>
<td>$30</td>
<td>$40 Most recent hemoglobin A1C Level &lt;7.0%</td>
</tr>
<tr>
<td>3045F</td>
<td>$25</td>
<td>$40 Most recent hemoglobin A1C Level 7.0%-9.0%</td>
</tr>
<tr>
<td>1111F</td>
<td>$20</td>
<td>$75 Discharge medications reconciled with the current medication list in outpatient medical record</td>
</tr>
<tr>
<td>1100F</td>
<td>N/A</td>
<td>$10 Patient screened for fall risk; two or more falls in the last year or fall with injury in the last year</td>
</tr>
<tr>
<td>1101F</td>
<td>N/A</td>
<td>$10 Patient screened for fall risk; no falls in the last year or one fall with no injury in the last year</td>
</tr>
<tr>
<td>0518F</td>
<td>N/A</td>
<td>$40 Falls plan of care documented</td>
</tr>
</tbody>
</table>
Provider Initiatives – Process for Supplemental Data Submission

Definitions
BestPractice is an innovative payment program that rewards providers for quality and efficiency in the management of patients’ health. BestPractice is designed to improve provider reimbursement through predictable monthly payments, in addition to fee-for-service payments that encourage overall health and prevention. Providers may have an increase or decrease in their monthly payments related to how they score on quality metrics, which are primarily based on Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

- BestPractice uses HEDIS specifications as guidelines for applicable time frames and appropriate ICD-10, CPT and HCPCS codes for services provided during the measurement year. This information is incorporated into our Quality Measure Guide, available at bcbswny.com/provider.

Performance Adjustment Factor (PAF) is an adjustment to the monthly payment based on the BestPractice evaluation incorporating a provider’s quality (as determined by HEDIS compliance for select measures) and medical efficacy, as compared to community peers.

Pay for Performance (P4P) is an incentive program that provides additional financial incentives to providers for meeting specific quality metrics.

- Each measurement year, P4P measures are identified and communicated in writing and posted on our website.
- Primary care providers and select specialty providers are eligible for P4P.
- P4P uses HEDIS specifications as guidelines for applicable time frames and appropriate ICD-10, CPT and HCPCS codes for services provided during the measurement year. This information is incorporated into our Quality Measure Guides, available on our secure website.

Risk Manager™ is an online analytical tool that assists providers in identifying quality- and cost-drivers. It provides high-level overviews and patient-level details that evaluate patient risk levels, identify gaps in care and support population management efforts. Information is refreshed monthly. Data includes but is not limited to: claims, medical enrollment, lab results, provider files, and state immunization information systems (NYSIIS).

Measurement year is the year in which the service occurs. This is usually the calendar year before the HEDIS reporting year. For example, HEDIS (reporting year) 2019 results are for measurement year 2018.

Reporting year is one year following the year reflected in the data. For example, HEDIS 2019 reporting year is for measurement year 2018.
Retrospective Measure is a measure that has a time period prior to the current measurement year. For example, the colorectal cancer screening measure has a retrospective time period for colonoscopies of 9 years including the measurement year (total of 10 years). If the current measurement year is 2018, any colonoscopy done from the beginning of 2009 through the end of 2018 would satisfy the measure.

- Retrospective measures include but are not limited to: Cervical Cancer Screening, Breast Cancer Screening, Colorectal Cancer Screening and Diabetes Care Eye Exam.
- Retrospective measures may or may not be part of any given year’s P4P program.

Purpose
The standard way to close a member gap in care is to make sure that claim(s) have been submitted with the appropriate CPT and/or ICD-10 code. All claims must be submitted in a timely manner. In order to reflect accurate risk scored for your patients, please be sure that all diagnoses affecting treatment and care are thoroughly documented and coded to the highest specificity. However, there are instances where it is not possible to submit a claim (e.g., for a retrospective measure or for services where BlueCross BlueShield is a secondary payer.) The purpose of this policy is to describe the proper procedures to ensure that providers receive credit for following the appropriate steps to close their patients’ gaps in care.

Policy
- Primary care providers and select specialty providers are eligible for provider performance initiatives.
- BestPractice PAF will be based on submitting appropriate coding (ICD-10, CPT, HCPC, LOINC) on services performed during the current year. This process is referred to as administrative claims data.
- Medical record submission for supplemental data incentives will begin July 1 annually. In order to get credit for P4P measures, services rendered in the current year must be billed with the appropriate coding (ICD-10, CPT, HCPC, LOINC), as medical records for current year services will not be accepted for those gaps in care closures. The only exception for current year services is when BlueCross BlueShield is the member’s secondary insurance.
  - Medical record submission for members who had services rendered within a retrospective time period (per HEDIS technical specifications) will be accepted from July 1 through the designated time period. Retrospective measures include but are not limited to: Cervical Cancer Screening, Breast Cancer Screening, Colorectal Cancer Screening and Diabetes Care Eye Exam.
  - Accepted medical records will be entered into Risk Manager™. Please allow up to 60 days for these updates to appear in the member gap in care reports.

Procedure for assessing member gaps in care:
1. Run a report using Risk Manager™.
2. For each patient and measure, determine the following:
a. If the service required by the quality measure was NOT rendered, the provider office may reach out to the patient to coordinate scheduling the service.
b. If the service WAS rendered, determine if a claim has been submitted to BlueCross BlueShield.
c. If a claim was submitted in the past 60 days, allow time for the claim to process. Do not submit any medical record documentation at this time.
d. If a claim was not submitted, do so now. Use the appropriate CPT and/or ICD-10 code.
e. If the service was rendered prior to the current year, such as for a retrospective P4P measure, or if BlueCross BlueShield is the secondary payer, submit the medical record documentation using the appropriate Quality Compliance Form (QCF). Forms are available at bcbswny.com/provider. Medical records will not be accepted unless accompanied by the appropriate QCF. A QCF must be filled out for each measure for each individual member’s medical record. The documentation should be faxed to the Clinical Team for review at (716) 887-8640.

Physician Incentive Funds
The incentive pool will be funded by BlueCross BlueShield based on our annual membership numbers.

Provider Experience Team
The goal of the Provider Experience Team (PE) is to work collaboratively with the provider/provider group to decrease medical costs while increasing the quality and efficiency of the provider’s practice. This is accomplished by providing physicians with their own individual data that pertains to their unique patient population, and other performance enhancement opportunities.

The PE team process consists of a practice account manager and a provider practice consultant visiting a provider/provider group to discuss utilization trends and gaps in care. (A clinical pharmacist and medical director are available upon request.)

The meeting usually consists of two portions, a review of the BestPractice Quality and Efficiency reports, Pay for Performance programs and the physician support (clinical) portion.

After review of the program information, the practice account manager will then review analysis for various clinical population management and quality reporting using our Risk Manager™ (RM) tool. This online tool allows practices to proactively manage gaps in care and maximize their quality incentive dollars. All of the clinical reports will demonstrate ways the physician can affect change as well as lower costs associated with the delivery of patient care. There is also discussion regarding the provider’s efficiency in the context of their particular case mix and cost analysis for high cost episodes and pharmacy prescribing information in addition to other clinical information.
Section 15 - Member Information

Member Rights and Responsibilities

As partners in health care, each of us has rights and responsibilities that we must follow in order to make the most of our members’ health benefits. The following rights and responsibilities apply to our members:

Member Rights
Members have the right to:

- Receive information about the health plan, its services, its practitioners and providers, and member rights and responsibilities
- Treatment with respect, consideration, dignity and privacy
- Information about all services available through the health plan, including how to obtain emergency and after-hours care
- Confidentiality of their medical records
- Candid discussions concerning appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage
- Voice complaints or appeals about the health plan or the care provided
- Request to see the physician selected for their primary care services instead of another member of his/her office staff for an office visit, if they are willing to wait for an available appointment
- Make recommendations regarding the health plan’s member right and responsibilities policies

Patient Rights
As a patient, our members have a right to expect the following from their physicians or other providers:

- To participate in decisions concerning their health care
- To refuse treatment to the extent permitted by law, and to be informed of the medical consequences of that action
- To obtain from their physician or other health care provider complete and current information concerning a diagnosis, treatment, or prognosis, in terms they can reasonably be expected to understand; when it is not advisable to give such information to a member, the information shall be made available to an appropriate person on their behalf
- To receive information from their physician or other provider necessary to give informed consent prior to the start of any procedure
- To know the name and qualifications of all their caregivers; information can be obtained from the provider or the administrator of any health care facility
- If a member feels that their physician has not given them the kind of service they have the right to expect, our members have the right to follow the complaint procedure for Quality of Care Access Review; they can refer to their member handbook or contact customer service
Member Responsibilities

- Establish themselves as a patient of the physician they have selected for their primary care services
- Follow the instructions and guidance of health care providers
- Provide honest and accurate information concerning their health history and status
- Participate in understanding their health problems and developing mutually agreed upon treatment goals
- Follow carefully the health plan’s policies and procedures as described in their member handbook and their contract(s) and rider(s)
- Be sure that their primary care physician coordinates any health care they receive in order to receive the highest level of benefits, if applicable under the terms of your plan coverage
- Carry their member ID card with them and present it when seeking health services
- Advise their health plan of any changes that affect them or their family such as birth, change of address, or marriage
- Submit all bills they receive from a non-participating provider within one year from the date of service
- Notify their health plan when anyone included in their coverage becomes eligible for Medicare or any other group health insurance
- Keep their health plan informed of their concerns about the medical care they receive
- Pay appropriate copayments/deductible/coinsurance or other patient responsibility to providers when services or supplies are received

Grievance and Appeal

If a member encounters any concerns, they can usually be resolved with a call to the Member Services Department.

Unresolved complaints or requests to change contractual determinations that are not in regard to medical necessity determinations or experimental/investigational determinations can be reviewed through the grievance and appeal procedures. Adverse medical necessity determinations or experimental/investigational determinations are reviewed through the Utilization Management appeals process.

Our grievance and appeal procedure is designed to ensure a timely review of:

- Our members concerns regarding our policies and procedures; or
- Any decision that we have made regarding a service that they believe is covered by BlueCross BlueShield, or should be provided to them as part of their coverage.

A grievance can be requested for any determination made by BlueCross BlueShield other than a decision that a service is not medically necessary or is experimental or investigational in nature. Examples of concerns that may be reviewed under our grievance and appeal procedure include, but are not limited to, the following:
denial of a referral to a specialist,
• denial of coverage for a referred service,
• denial because a benefit is not covered according to the terms of the member's contract(s),
• denial of a benefit because it was provided by an ineligible provider or at an ineligible place of service, and
• a determination that they were not a member of BlueCross BlueShield at the time services were rendered.

Traditional Indemnity members, including PPO/EPO, and for individual market products sold on or off the exchanges have a one level grievance process with the following timeframes for response:

• Urgent cases: 72 hours
• Pre-service: 30 calendar days
• Post-service: 60 calendar days

There is a two level grievance and appeal process for HMO and POS members, and for small group products sold on or off the exchanges described below.

As always, you may file a grievance at your discretion. BlueCross BlueShield will not take any discriminatory action against you because you have filed a grievance or an appeal.

Designating a Representative

Members may designate someone to represent them with regard to their grievance or appeal at any level. If a representative is designated, we will communicate with the member and their representative, unless directed otherwise. In order to appoint a representative, the member must complete, sign, and return the Appointment of Authorized Representative Form. This form can be requested by calling Member Services at 1-800-544-2583.

In cases involving urgent care, a health care professional with knowledge of their medical condition may act as their authorized representative without the need to complete the Appointment of Authorized Representative Form.

Initiating a Grievance (Level I)

Any time BlueCross BlueShield denies a referral or determines that a benefit is not covered under the member's contract(s), the member will receive notification of our grievance procedures. A written or oral grievance may be filed up to 180 days after the receipt our original determination. Requests for a grievance should state the name and identification number of the member for whom the benefit or referral was denied. It should also describe the facts and circumstances relating to the case. Oral or written
comments, documents, records, or other information relevant to the grievance may be submitted.

A grievance may be initiated by calling our Member Service Department at 1-800-544-2583. Our Member Services Department hours are 8 a.m. - 7 p.m., Monday through Friday. When our offices are closed, the member may notify us about the grievance by leaving a detailed message with our answering service. We will acknowledge receipt of the oral grievance by telephone within one business day of receipt of the message. You may contact Customer Service for language assistance free of charge or if you have special needs.

Please send all written requests for a grievance to:

Grievance Department
BlueCross BlueShield of Western New York
PO Box 80
Buffalo, NY 14240

We will send a written acknowledgment of receipt of a member's grievance within 15 calendar days. This letter will include the name, address and telephone number of the department that is handling the grievance. It may be necessary to ask for additional information before we can review the grievance. If this is necessary, we will contact the member.

A Member Services Representative who was not involved in the initial determination and who is not a subordinate of the initial reviewer, will thoroughly research the case by contacting all appropriate departments and providers. The Member Service Representative will review all relevant documents, records, and other information including any written comments, documents, records and other information the member or their representative have submitted.

If the issues involved are of a clinical nature, it will be reviewed by a health care provider who was not involved in our initial determination and who has appropriate training and experience in the field of medicine involved in the medical judgment. Clinical matters would be those that require appropriate medical knowledge and experience in order to make an informed decision. The member will be contacted within the following time frames:

In urgent cases, when a delay would significantly increase the risk to the member’s health, a decision will be made and communicated to the member by telephone within 48 hours after receipt of the grievance. The member will also be contacted in writing within two business days of the notice by telephone.

In cases involving requests for referrals or disputes involving contract benefits and all other non-urgent cases, a decision will be made and communicated to the member as follows:
• **Pre-Service Claims**: In writing within 15 calendar days after receipt of the grievance.
• **Post-Service Claims**: In writing within 30 calendar days after receipt of the grievance.

Our response to our member will include the detailed reasons for our determination, the provisions of the contract, policy or plan on which the decision was based, a description of any additional information necessary for the member to perfect their claim, and why the information is necessary, the clinical rationale in cases requiring a clinical determination, the process to file an appeal and an appeal form.

**Appealing an Upheld Denial (Level II)**

If a member remains dissatisfied with the outcome of their grievance, they may file an appeal. A request for an appeal should include any additional information the member feels is necessary. Members have 60 business days from the time they receive the grievance determination to submit an appeal to BlueCross BlueShield. They may submit their request for an urgent appeal verbally or in writing. For a non-urgent appeal, they may submit a written request in the form of a letter or use our appeal form. The member will receive a copy of our appeal form with the original grievance decision. They may submit any written comments, documents, records or other additional information with their appeal.

We will send written acknowledgment of our receipt of the appeal request within 15 calendar days. This notice will include the name, address and telephone number of the individual who will respond to the member’s appeal.

Non-clinical matters will be reviewed by a panel comprised of representative staff from our Network Services, Member Services, Quality Management and Utilization Management areas who were not previously involved in your grievance.

If the appeal involves a clinical matter, it will be reviewed by a panel of personnel qualified to review clinical matters. This includes licensed, certified, or registered health care professionals who did not make the initial determination. At least one of the health care professionals reviewing the appeal will be a Clinical Peer Reviewer. (A Clinical Peer Reviewer is a licensed physician or a licensed, certified, or registered health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment.)

We will make a decision regarding the appeal and send the member notification within the following periods:

- In urgent cases, a decision will be made and notice provided by telephone within 24 hours after receipt of the Level II grievance appeal followed by written notice within two business days after receipt of the appeal.
- For non-urgent pre-service claims, a written decision will be sent within 15 calendar days from receipt of the appeal.
For post-service claims, a written decision will be provided within 30 calendar days from receipt of the appeal.

Our notification to the member with regard to their appeal will include the detailed reasons for our determination, the provisions of the contract, policy, or plan on which the decision was based, and the clinical rationale in cases where the determination has a clinical basis.

**Member Grievance/Appeal**

Upon written request, and free of charge, our members have the right to have access to copies of all documents, records, and other information relevant to their claim and details regarding diagnosis/treatment. Members also have the right to request, in writing, the name of each medical or vocational expert whose advice was obtained in connection with their claim.

Upon written request, and free of charge, members have the right to an explanation of any scientific or clinical judgment for the determination to deny their claim that applies the terms of their contract, policy or plan to your medical circumstances.

Upon written request, and free of charge, members have the right to a copy of each rule, guideline, protocol or similar criteria that was relied upon in making the determination to deny their claim.

Members have a right to file a complaint at any time with the New York State Department of Health at 1-800-206-8125 or the NYS Department of Financial Services Consumer Service Bureau at 1-800-342-3736.

For questions about your appeal rights or assistance you can contact the Employer Benefits Security Administration at 1-866-444-3272 or Community Service Society of New York, Community Health Advocates at 1-888-614-5400.

Members may have the right to bring a civil action under the Employment Retirement Income Security Act of 1974 (ERISA) §502 (a) if they file an appeal and their request for coverage or benefits is denied following review. Members have this right if their coverage is provided under a group health plan that is subject to ERISA.

**Quality of Care Access Review**

As a BlueCross BlueShield member, members have the right to ask us to look into their concern about quality of care or timely access to a provider. We closely track all complaints. If we receive similar complaints from our customers about a provider during a certain time period, we address those issues with the provider. This is our informal process.

We also have a formal process. At a member's request, we will investigate their concern by requesting records or other documentation. Our Medical Director reviews this
information. If necessary, our Medical Director will meet with the provider to discuss the concern.

If a member has a concern or problem regarding their ability to see a BlueCross BlueShield provider in a timely fashion or the quality of care they receive, they can contact our Member Services Department at 1-800-544-2583.

We will send the member a letter that explains the complaint process and gives them a number to call if they wish to file a formal complaint. It also explains the appeal process if the member disagrees with the way our staff handles their concerns.

**Unresolved Disputes**

We always recommend that members follow our grievance or utilization review process to remedy any issues concerning their coverage. However, if they are not satisfied with any BlueCross BlueShield decision, members have the right to contact the New York State Department of Financial Services or the New York State Department of Health (DOH). The addresses and telephone numbers for these agencies are:

New York State Department of Health  
Corning Tower  
Albany, NY 12237  
1-800-206-8125

New York State Department of Financial Services  
One Commerce Plaza  
Albany, NY 12257  
1-800-342-3736

**Additional Member Resources**

**Health Advocate**  
1-800-359-5465  
A personal health care coaching and patient advocacy service members can call anytime they need help navigating the health care system

**Behavioral Health Assistance**  
1-877-837-0814  
For assistance in obtaining mental health and substance abuse treatment

**Fraud and Abuse Hotline**  
1-800-333-8451  
reportfraud@bcbswny.com

**Express Scripts®**  
1-800-939-3751  
For questions on pharmacy benefits
Section 16 - Wellness and Health Promotion

Health and Wellness Programs

BlueCross BlueShield is committed to helping our members take an active role in achieving and maintaining good health. That's why we offer health and wellness programs. These programs support your efforts to keep our members healthy by providing them with coverage benefits for health promotion and education services.

Members are more likely to attend health and wellness classes if they receive encouragement from their physicians or other providers and we invite providers to encourage their patients to participate in the programs. We reimburse the health education provider directly, so the member may attend wellness classes without any out-of-pocket expense.

BlueCross BlueShield has an extensive network of credentialed providers offering health education classes. Patients do not require a referral or written approval for most approved programs.

Classes are currently offered in the following categories:

- Diabetes education
- Maternal and infant health
- Nutrition
- Physical activity
- Smoking cessation
- Stress management
- Weight management

We also offer programs on topics such as AIDS/HIV, children and adolescent health, arthritis, cancer information, holistic health, substance abuse, senior health, women's health, asthma, heart health, and a variety of support groups.

Members may view a current list of health and wellness programs by visiting the Health & Wellness section on our member website at bcbswny.com.

We encourage our members to take a variety of classes in order to enhance their overall wellness. Programs of similar topics (stress management, diabetes education, nutrition etc.) are limited to one class/program per year with the exception of fitness programs (Pilates, yoga, spinning), which are limited to two programs each year. Maternal and infant health classes are unlimited.

To register, members should contact the health and wellness program provider directly. Members are able to verify program eligibility by calling the customer service number on the back of their BlueCross BlueShield member identification card.
Tobacco Cessation
We offer members access to complimentary smoking cessation counseling and nicotine replacement therapy [NRT] through our Roswellness InhaleLife program. BlueCross BlueShield also has health education literature on smoking cessation that you may use when counseling your patients. This information will assist you in creating a systematic approach to helping patients quit using tobacco products. For additional information or to download materials, visit the Health & Wellness section on our member website at bcbswny.com.

My Health Member Website
My Health, our secure member website, has useful health resources for our members, your patients. When logging into My Health, members will find:

- Self-paced wellness programs on a variety of topics
- Video coaching
- Wellness-related social communities and blogs
- A-to-Z health library with symptom checking capabilities
- Health assessment survey tool (see information below)
- Member only discounts to fitness centers, Jenny Craig®, NutriSystem®, Zumba® and more

Health Assessment
One of the greatest opportunities in controlling rising medical costs is staying healthy. We constantly offer resources to help members so that they can be proactive in managing their health. With that in mind, we developed a health assessment to help assess, maintain and improve the health of our members.

An individualized survey is administered to patients seeking information about their current health status, medical conditions, lifestyle habits, recent medical care and pertinent biometric values, as well as health areas in which they desire improvement.

The health assessment presents a personalized profile report that identifies the health status and risk of survey respondents. This report is distributed to the member. We encourage members to use it as a tool in managing their health issues. This data is a valuable tool for our Lifestyle Management coaches to utilize in working with members on addressing modifiable risk factors.

Additionally, the data we gather from this survey is aggregated, analyzed and used to develop informed, targeted health promotion and education programs through our health promotion department. The data provides a better picture of the health status and risks of our member population and allows our Health Promotion, Health Care Quality Improvement and Care Management personnel new avenues for intervening with our higher-risk members.

The health assessment is located on the member website My Health.
Discounted Services
We are committed to helping our members take an active part in their good health. That's why we have partnered with local and national businesses to offer health-related services at a discounted rate.

See the Member Discounts page under the Member Benefits section on our website.
Section 17 - Right Start Program

Beneficial for Physicians, Mothers and their Babies

Pregnant women need care, support and education from the first signs of pregnancy, through birth and after the baby is born. To ensure all our pregnant members receive the services they need, we recommend our Right Start Program. This program covers moms and their babies from the time the pregnancy is identified to six months after birth.

The Right Start Program begins with our prenatal assessment form. Registered moms will receive prenatal education and interventions when identified as high-risk. Of particular interest to physicians are the following elements of the program: $100 reimbursement for physicians to enroll high-risk patients prior to their 15th week gestational period.

Please click on the Right Start clinical practice guidelines and prenatal referral form.

Newborn Education Component

New mothers may not recognize the basic signs of illnesses in their babies, simply because they lack the necessary education, experience and materials. As a result, these moms frequently take their newborns to the emergency room when possibly home care was all that was needed.

To help educate new moms about basic care of their newborns, we are working with hospital nurseries to identify mothers who want or need newborn education. Nursery department staff will initiate basic wellness education, along with instruction about recognizing signs and symptoms of newborn illnesses. Through home nursing visits, education will continue over a six-month period when needed, or through telephone intervention.

By providing newborn care information to new moms, we hope to:

- Teach moms how to recognize signs of illness in their babies.
- Help them to better communicate with their baby's pediatrician.
- Avoid unnecessary trips to the emergency room.
- Reinforce proper preventive care and immunization schedules with moms.

Fact Sheet

The Right Start Program is designed to follow mother and child from the time the pregnancy is identified to six months after birth. All pregnant women should be registered during their first trimester. They will receive educational support and materials. Patients who are identified as high-risk will also receive case management services that reinforce the physician's care instructions and offer additional patient education. In-home nursing visits or telephonic options are available. After the birth of
their babies, new moms will receive newborn education to help them care for their babies.

All pregnant patients should be enrolled in the Right Start Program. The Right Start Program's four major components are:
- Enrollment of pregnant patients in the program
- Prenatal education for all patients
- Interventions for high-risk patients
- Health education for newborn care

**Enrollment by Physician**

Physicians need to complete a prenatal assessment form for each pregnant patient at the time of her first prenatal visit. **It's important that we receive a form for every member, not just those who may be high-risk.** Please fax or mail the completed forms to us at the number or address on the form. Forms can also be electronically submitted online on our website.

Once received, we will enroll the patient in our Right Start program and send you $100.00. This $100.00 is an incentive payment for referring our high-risk members to the program prior to the member's 15th week gestational period and does not apply to any medical services you provide.

**Prenatal Education**

The program emphasizes the importance of early and ongoing prenatal care. Women will also be encouraged to attend one of our many prenatal education classes. Additionally, education regarding importance of postpartum care and follow-up are reviewed.

**Interventions for High-Risk Patients**

Patients who are identified as high-risk on the prenatal assessment form will be evaluated to possibly receive an at home risk assessment by a nurse specializing in maternal or obstetrical care. The nurse will act as a liaison between you and your patient by reinforcing your care instructions and offering patient education. If needed, with the consent of the mother, additional monthly home visits will be scheduled. One example is a home visit from a registered dietician to assist the mother with meal planning for gestational diabetes, hypertension, obesity, hyperemesis or other nutritional concerns identified by the physician. There is no member copayment for any nursing visits coordinated through the Right Start Program.

**HIV Services**

DOHM (AI 99-01) is the standard of care for HIV services.

- a. Provide all pregnant women with HIV counseling and education;
- b. Offer the pregnant woman confidential HIV testing; and
- c. Provide the HIV positive woman and her newborn infant the following services or make the necessary referrals for these services:
  1. Management of the HIV disease
2. Case management to assist in coordination of necessary medical, social and addictive services

HIV pretest counseling should be provided to all prenatal clients. If a woman is found to be HIV positive, the clinician ordering the HIV test is responsible for arranging for a follow up appointment to an HIV specialist or designated AIDS Center.

**Universal Recommendation for Testing of Pregnant Women**

New York’s regulatory framework for preventing mother-to-child transmission (MTCT) of HIV has proven highly effective and remains unchanged. The only exception is that the 2017 updates to HIV testing do remove the requirement to obtain consent for HIV testing in writing or orally. All pregnant women must be offered HIV testing as a clinical recommendation as early as possible during pregnancy. Third trimester testing is recommended for all pregnant women in NYS who tested negative for HIV earlier in their pregnancy. When being offered HIV testing, the woman should be provided the key points of information and informed of her right to decline the test. Pregnant women who are diagnosed as living with HIV should be linked to treatment as soon as possible to protect their health and prevent transmission of HIV to the newborn.

Women who present to the labor/delivery setting with no history of HIV testing during their current pregnancy should be counseled with the recommendation for HIV testing. If the mother declines testing in labor/delivery, the mother should be informed that her newborn will be tested immediately at birth without her consent. All newborns, including those tested at birth, are routinely tested for HIV through the New York State Newborn Screening Program. Documentation of the woman’s prenatal HIV testing should be forwarded to the delivering hospital and a copy of the mother’s HIV test history results should be placed in the newborn’s medical record to ensure administration of medications during labor/delivery and initiation of medication to the infant for the first four-six weeks of life or until the infant is definitively excluded from HIV infection. To access the latest regulations visit: [https://regs.health.ny.gov/content/section-69-13-responsibilities-chief-executive-officer](https://regs.health.ny.gov/content/section-69-13-responsibilities-chief-executive-officer) or [https://regs.health.ny.gov/content/section-40521-perinatal-services](https://regs.health.ny.gov/content/section-40521-perinatal-services)

**Acute HIV Infection During Pregnancy**

The acute HIV infection in pregnancy guidelines recommend the following:

- Confirmation of preliminary positive expedited HIV test results
- Vigilance for acute HIV infection in pregnant women who present with a compatible clinical syndrome, even if a previous HIV antibody test during current pregnancy was negative
- Evaluation for acute HIV infection in pregnant or breastfeeding women who present with a febrile “flu” or “mono” like illness, or rash that is not otherwise explained
- Immediate screening for suspected acute HIV infection by obtaining an HIV serologic screening test in conjunction with a plasma HIV RNA assay (a fourth-generation HIV antigen/antibody combination test is the preferred serologic screening test, if available)
• Repeat HIV RNA testing from a new specimen to confirm the presence of HIV RNA if HIV RNA or antigen was detected in the absence of HIV antibody
• Baseline genotypic testing and initiation of ART while waiting for the results of resistance testing

For HIV positive women, documentation should reflect receipt of appropriate care.

Labor and Delivery
• Offering of testing during labor and delivery for those who do not have documented third trimester HIV test results
• Availability of expedited testing of pregnant women who present for delivery without documentation of a negative HIV test

Partner Services and the Role of Partner Services Programs
Medical providers or their designee must explain to all newly diagnosed patients the importance of notifying any sexual or needle-sharing partners that they may have been exposed to HIV. Partner services is a cornerstone of HIV prevention efforts that provides an opportunity for sexual or needle sharing contacts of a person living with HIV to be offered testing in a timely manner, and if diagnosed with HIV infection, be linked into care. Every physician or other person authorized to order diagnostic testing is required to report HIV and AIDS diagnoses to the health department. This report must include identifying information about any contacts known to the clinical provider or provided to the clinical provider by the patient.

The HIV/AIDS Provider Portal described in Section 7, may be used to report cases, including partners and to request assistance from the health department with partner notification. As part of post-test counseling, the following must be provided to the patient:

1. An explanation of the importance of notifying sexual or needle sharing partners to prevent further transmission, and to promote early access of exposed persons to HIV testing, health care, and prevention services;
2. A description of notification options and assistance available to the protected individual;
3. A discussion about the risk of domestic violence and screening for domestic violence prior to partner notification in accordance with NYSDOH domestic violence screening protocol;
4. The fact that known contacts, including a known spouse, will be reported to the health department. That protected persons will also be requested to cooperate in contact notification efforts of known contacts and that protected persons may name additional contacts they wish to have notified with the assistance of the provider or authorized public health officials; and
5. An explanation that the name and other information about the person living with HIV will be protected during the contact notification process.

The NYSDOH Partner Services Program and the NYC Health Department Contact Notification Assistance Program (C-NAP) provide a wide range of services, including:
performing notifications; assisting patients with decision making; and consulting with health care providers. In some situations, Partner Services Specialists can meet with the patient at the same time that the laboratory results are given to assist with post-test counseling and development of a partner notification plan. Additional NYSDOH/NYC Department of Health and Mental Hygiene (NYCHMH) services may be available such as assistance in locating persons who test positive but who do not return for their results. For more information about partner services and how to contact partner services programs throughout NYS, visit:

IMPORTANT POINT:
In recognition of the need for ongoing partner services beyond the time of initial diagnosis of HIV, the 2016 updates to the NYSDOH Regulations formally prioritized partner services for people who were previously diagnosed with HIV who are at elevated risk of transmitting the virus to others. Several factors are considered as evidence of elevated risk of transmitting the virus to others. Those factors include that the individual: 1) is not engaged in health care services, 2) is not virally suppressed; 3) has had a recent STD; or 4) has recently moved back to NYS from another jurisdiction.

In addition, the updated NYSDOH Regulations remove the requirement that data on the partners of HIV cases be destroyed after three years. The NYSDOH or local health department will establish a new policy for record retention and disposition.

Health Care Provider HIV Reporting Requirements
New York State Public Health Law Article 21 requires the reporting of persons with HIV infection and AIDS to the NYSDOH. The law also requires that reports contain the names of sexual or needle-sharing partners known to the medical provider or whom the patient wishes to have notified. Under the federal HIPAA Privacy Rule, public health authorities have the right to collect or receive information “for the purpose of preventing or controlling disease” and in the “conduct of public health surveillance…” without further authorization. This provision of HIPAA regulations authorizes medical providers to report HIV/AIDS cases to the NYSDOH or NYC Health Department without obtaining patient permission.

The Medical Provider HIV/AIDS and Partner/Contact Report Form (PRF) (DOH-4189), must be completed within 14 days of diagnosis for persons with the following diagnoses or with known sex or needle-sharing partners:

- **Initial/New HIV diagnosis** - First report of testing documenting HIV diagnosis.
- **Previously diagnosed HIV (non-AIDS)** - Applies to a medical provider who is seeing the patient for the first time.
- **Initial/New diagnosis of AIDS** - Including <200 CD4 cells/μL or an opportunistic infection (AIDS-defining illness).
- **Previously diagnosed AIDS** - Applies to a medical provider who is seeing the patient for the first time.
- **Known sex or needle-sharing partners of persons with diagnosed HIV infection.**
Clinicians seeing for the first time a patient previously diagnosed with HIV or AIDS should report to the NYSDOH using the PRF. The rationale is that this is often the only indication the NYSDOH receives of a patient new to New York, but not newly diagnosed, and perhaps not in need of extensive Health Department Partner Services. Additionally, particularly for the well suppressed patient who moves into NYS, the report by the clinician can be the only indication that the person is in fact HIV positive.

Information regarding electronic reporting via the HIV/AIDS Provider Portal (see below) or paper forms are available from the NYSDOH at 518-474-4284; clinicians located in NYC, call 212-442-3388. In order to protect patient confidentiality, faxing of reports is not permitted.

HIV/AIDS Provider Portal
The HIV/AIDS Provider Portal is an electronic system which enables clinicians to: 1) meet their reporting requirements electronically; 2) provide a mechanism for clinicians statewide to notify the NYSDOH that a patient needs linkage to Health Department Partner Services; and, 3) submit inquiries for patients with diagnosed HIV infection who are thought to be in need of assistance with linkage to or retention in HIV medical care. A NYSDOH Health Commerce System (HCS) Medical Professionals account is required. After logging into the HCS at https://commerce.health.ny.gov, select “Refresh My Applications List” on the left side and then under “My Applications” select HIV/AIDS Provider Portal. Follow the prompts to set up an account.

Laboratory Reporting Requirements
Laboratory reporting of suspected or confirmed positive findings or markers of HIV infection is mandated under New York State Public Health Law. Guidance has been prepared in an effort to assist permitted clinical laboratories and blood banks in meeting their obligations to report HIV-related laboratory test results, as well as other communicable disease markers. The guidance is available on the Wadsworth Laboratory website.

HIV laboratory reporting is an essential source of information for New York’s HIV surveillance efforts and maintaining high quality, complete data is critical to tracking progress toward National HIV/AIDS Strategy retention and care measures and NY’s effort to end the epidemic. To keep pace with advances in HIV care, testing technologies and disease monitoring, there have been some important changes to HIV laboratory reporting requirements. Laboratories and blood/tissue banks performing tests for screening, diagnosis or monitoring of HIV infection for NYS residents and/or NYS health care providers (regardless of patient residence) shall report the following laboratory tests or series of tests used in the diagnosis of HIV infection:

- All reactive/repeatedly reactive initial HIV immunoassay results AND all positive, negative or indeterminate results from all supplemental HIV immunoassays performed under the second or third step in the diagnostic testing algorithm, including HIV-1/2 antibody differentiation assay, HIV-1 Western blot, HIV-2 Western blot or HIV-1 Immunofluorescent assay;
• All HIV nucleic acid (RNA or DNA) detection tests (qualitative and quantitative), including tests on individual specimens for confirmation of nucleic acid-based testing (NAT) screening results;
• All CD4 lymphocyte counts and percentages, unless known to be ordered for a condition other than HIV;
• HIV genotypic resistance testing via the electronic submission of the protease, reverse transcriptase and integrase nucleotide sequence;
• Positive HIV detection tests (culture, P24 antigen).

All HIV-related laboratory reporting, including by NYC providers and for NYC residents, should be made directly to the NYSDOH, submitted electronically via the NYSDOH Electronic Clinical Laboratory Reporting System (ECLRS).

To improve the quality of data, and in keeping with changes that allow for enhanced use of surveillance data to improve linkage and retention in care, laboratories are required to report results using patient identifying, demographic and locating information, as well as the requesting provider and facility ordering the lab test. The 2016 update requires that when labs report HIV-related test results, the following information should be included:

• Patient name, date of birth, and other identifying information;
• Patient demographic information (e.g., sex at birth, race/ethnicity, etc.);
• Patient address and telephone number;
• Provider ordering the test and facility name;
• Complete provider and facility address and telephone number;
• Provider and facility National Provider Identification.

For a complete list of this information and instructions on how to report required data elements, please call 518-474-4284 or contact BHAELab@health.state.ny.us.

In Labor and Delivery Settings, recommendations are:
• Adoption of point of care rapid HIV testing in labor and delivery settings
• Availability of expedited HIV test results prior to delivery to allow maximum benefits of intrapartum ARV prophylaxis for the fetus
• Steps to follow when expedited HIV testing yields a preliminary positive result
• Steps to follow when definitive test results indicate HIV infection is present
• Steps to follow when HIV infection has been definitely excluded in the mother

Pregnant women and exposed infants lost-to-care require immediate action for re-engagement. HIV-positive pregnant women and their exposed infants are a priority when identified as lost-to-care and require immediate action for reengagement. Reengagement in care is especially important for HIV-positive pregnant women who are in their third trimester due to possible increasing viral loads from being non-adherent to ART, leading to increased risk of transmitting HIV to their infants. Ensuring exposed infants are engaged in care is critical during the first 4-6 months to ensure appropriate antiretroviral and opportunistic infection prophylaxis, as well as definitive documentation of the infant’s HIV infection status.
If routine attempts for reengagement of the HIV-positive pregnant woman or her exposed or infected infant(s) are not successful, please contact the NYSDOH Perinatal HIV Prevention Program at (518) 486-6048 or submit a request via the NYSDOH HIV/AIDS Provider Portal (see below) for assistance. New York City providers should call the NYC DOHMH Field Services Unit at (347) 396-7601 for assistance with reengagement of pregnant women.

Records and Reports
- Create and maintain records and reports that are complete, legible, retrievable and available for review; such records and reports shall include: a comprehensive prenatal care record for each pregnant woman that documents the provision of care and services required by this section and is maintained in a manner consistent with medical record confidentiality requirements
- A comprehensive prenatal care record should be maintained on each client. Entries should be complete, legible and accurately reflect any of laboratory testing and special procedures
- Records should be maintained in a manner that safeguards confidentiality requirements
- Develop/implement system to track trimester of entry, low birth weight (LBW) infants, number of prenatal visits, postpartum rate of return, number of c/sections, vaginal births after cesarean sections (VBACs), number of women choosing to breastfeed, and number of teen pregnancies
- An annual report should be accurately completed and submitted within expected time frame

Internal Quality Assurance
- Develop and implement written policies and procedures establishing an internal quality assurance (IQA) program to identify, evaluate, resolve and monitor actual and potential problems in patient care
- Implement IQA activities focusing on prenatal care within system wide QA program
- Develop policies/procedures establishing internal quality assurance plan for prenatal care program
- Recommend IQA should be multidisciplinary and review issues such as nutrition, psychosocial, educational methods, care coordination, risk assessment, and HIV services

Have periodic IQA meetings to discuss prenatal issues:
- A documented and filed prenatal chart audit performed periodically on a statistically significant number of current prenatal client records
- An annual written summary evaluation of all components of such audits
- A system for determining patient satisfaction and for resolving patient complaints
- A system for developing and recommending corrective actions to solve identified problems
- A follow-up process to assure that recommendations and plans of correction are followed
Prenatal chart audits should be performed using 85-40 indicators.

A tool to conduct chart audit should be developed.

Prepare written summary evaluation of audit findings on an annual basis. Maintain audit summary on file.

Develop system for determining patient satisfaction with prenatal program and resolving patient complaints. Recommend administering patient satisfaction survey during client’s third trimester or at the postpartum visit.

Documentation should include: summary reports of chart audit findings; analysis of outcome statistics; analysis of patient satisfaction survey results with recommendations to correct identified problems. All follow up is done in a timely manner.

**Postpartum Services**

Coordinate with the neonatal care provider to arrange for the provision of pediatric care services and patient services.

Stress importance of postpartum/pediatric visit to the mother during third trimester visits. Develop strategies to encourage client to return for postpartum visit (i.e., incentives). Implement missed visit policy for ‘no-shows.’

A postpartum visit with a qualified health professional shall be scheduled and conducted in accordance with medical needs but no later than eight weeks after delivery. For the interim, furnish each woman with a means of contacting the provider in case postpartum questions or concerns arise.

Provide home visits to assess needs (e.g., adjustment to parenting, feeding, etc.) as indicated. Refer to Care Coordination section for additional guidance. Contents of home visit should be documented in the record.

Postpartum visit should be scheduled no later than eight weeks post-delivery. Submit mechanism to schedule/follow-up on postpartum visit. Arrangements for pediatric care should be made.

Develop arrangements for client to contact provider between delivery and scheduled postpartum visit.

**Postpartum Visit Components**

- Identify any medical, psychosocial, nutritional, alcohol treatment and drug treatment needs of the mother or infant that are not being met;
- Refer the mother or other infant caregiver to resources available for meeting such needs and provide assistance in meeting such needs where appropriate;
- Assess family planning needs and provide advice and services or referrals where indicated;
• Provide preconception counseling as appropriate and encourage a preconception visit prior to subsequent pregnancies for women who might benefit from such visit;
• Refer infants for preventive and special care.

Establish a protocol to provide all postpartum components of care (i.e., identify needs of woman/infant, necessary referrals, family planning, etc.)

Postpartum documentation should include: delivery outcome, maternal physical exam, health status of mother/infant including medical, nutritional, psychosocial needs with referrals.

Use a standardized medical record with postpartum section or separate postpartum visit tool outlining indicated components of care.
If you have questions about the Right Start Program please call 1-800-871-5531. Supporting Documentation is found in the archive at the end of this manual (Appendix 3: Forms & Information.)

• Assessment Form
• NYSDOH Best Practices for Breast Feeding
• Early Risk Identification for Consultation
• Ongoing Pregnant Risk Identification for Consultation
• Interpretive Guidance for Prenatal Care: Guidance For Prenatal Standards

**Medicaid Prenatal Guidelines**
The New York State Department of Health worked with internal and external stakeholders to develop updated prenatal standards of care for all pregnant women enrolled in Medicaid. Additionally, BlueCross BlueShield has adopted these guidelines for all other lines of business for the maternity program.

These comprehensive changes will improve the quality of prenatal/postpartum care provided to pregnant women.

Please review the clinical guidelines at:

[health.ny.gov/health_care/medicaid/standards/prenatal_care](http://health.ny.gov/health_care/medicaid/standards/prenatal_care)
Section 18 - Behavioral Health and Chemical Dependency

BlueCross BlueShield of Western New York Behavioral Health Utilization Management department performs all the following inpatient and outpatient utilization review services for BlueCross BlueShield members:

• Preauthorization
• Level of care determinations
• Medical necessity determinations
• BH out-of-plan (OOP) referral requests
• Claims review and determinations

Behavioral Health Utilization Management follows the same regulatory requirements and processes outlined in Section 5 Utilization Management

For questions relating to any behavioral health services, you can call 1-877-837-0814. You will be directed to the appropriate area.

Preauthorization Requirement for Mental Health Services

• Preauthorization is required for all inpatient mental health services
• Observation status, when used as an alternative to an acute hospital admission, is eligible for reimbursement for patients who meet InterQual® observation criteria
• The routine outpatient mental health services in a member’s benefit year do not require preauthorization for most plans

Please verify all preauthorization requirements at wnyhealthenet.org

Preauthorization Requirement for Substance Use Disorder Services

Inpatient/Facility Admissions

NY State Opioid Legislation – (For applicable plans/providers)

No preauthorization is required for the initial 14 days of medically necessary inpatient treatment for SUD in New York State Office of Alcoholism and Substance Abuse Services (OASAS) licensed facilities that are participating in the BlueCross BlueShield network. Levels of care include detoxification, inpatient rehabilitation, and residential treatment. Although preauthorization is not required, facilities are required to provide the health plan with notification of the admission and the initial treatment plan within 48 hours of admission.

• The facility is also required to perform daily clinical review, including “periodic consultation” with the plan to ensure the facility is using the OASAS Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) tool.
• If the facility fails to notify the health plan of either the inpatient admission or the initial treatment plan within 48 hours of the admission, the health plan may begin concurrent review immediately upon learning of the admission, even if it is during the initial 14-day period.
• A health plan may also perform a retrospective medical necessity review of the treatment provided during the initial 14-day period and issue medical necessity denials up to and including the initial 14 days if the admission is not supported by LOCADTR tool. Members cannot be billed for services that do not meet.

All other inpatient facilities or benefit plans that are not covered by the above NYS Opioid Legislation require preauthorization.

Observation status, when used as an alternative to an acute hospital admission, is eligible for reimbursement for patients who meet Level of Care for Alcohol and Drug Treatment Referral (LOCADTR 3.0) tool.

The routine outpatient substance use disorder services in a member’s benefit year do not require preauthorization for most plans.

Please verify all preauthorization requirements at wnyhealthenet.org.

Outpatient Preauthorization Process
No registration or preauthorization is required for routine mental health or substance use outpatient visits in a member’s benefit year.

Please be advised that a few self-funded plans have elected to continue requiring registration at the first visit and medical necessity review. Please verify all preauthorization requirements at wnyhealthenet.org.

Typical preauthorization workflow:

1. Please verify all preauthorization requirements at wnyhealthenet.org. Behavioral health services should be rendered and the appropriate claim for payment should be submitted.
2. A Behavioral Health request form is located on our website under Provider/Tools and Resources/Forms/Behavioral Health Forms/Outpatient Treatment Review Form. The form can be faxed to 1-716-887-7913, or you may call 1-877-837-0814.
3. BlueCross BlueShield reserves the right to request and review additional clinical information at any time.

Preauthorization does not guarantee payment. The member must have active coverage and the appropriate benefits at the time of the service. Please note it is the responsibility of the provider to ensure that preauthorization is in place. Requests will not be backdated for more than 30 days from the date of service.
Mental Health Parity Laws

Effective January 1, 2007, the New York State Mental Health Parity law—Timothy’s Law—was implemented. The law mandates that mental health benefits be aligned with the medical benefits in a member’s policy. Copayments, coinsurance and deductibles, benefit structures, and network requirements for mental health services cannot be any more restrictive than for medical benefits. On October 3, 2009, Federal Mental Health parity regulations became effective. The Federal law broadened the NYS mandate to include substance use disorder services and added specific requirements that changed the way member benefits and liabilities can be structured.

While most of these changes apply to all large group plans, small employer groups have the option to buy up to the full Federal Parity benefit. Please check at wnyhealthenet.org to determine what the benefit is for a particular member. Additional regulation may be published in the future.

Basic Small Group Benefits Without the Federal Parity Rider
A basic minimum benefit of 30 inpatient days and 20 outpatient visits for mental health is available each benefit year. The substance use disorder benefit is 60 outpatient visits. Inpatient substance use disorder benefits vary. The copay/coinsurance also varies under federal guidelines so it is important to check wnyhealthenet.org or call Provider Service.

Federal Benefits for Large Groups
Under Federal Parity, large group policies carry an unlimited, medically necessary mental health and substance use disorder benefit for both inpatient and outpatient services. The copay/coinsurance varies under Federal guidelines, therefore it is important to verify at wnyhealthenet.org or contact Provider Service.

Medicare Benefit Plans
Require authorization after the first 20 outpatient visits. Please verify all preauthorization requirements at wnyhealthenet.org.

Claims Submission and Provider Tools
Billing instructions are the same for all providers. Please see Section 13.

BlueCross BlueShield has created a variety of tools to help the staff in providers’ offices understand our contract benefits, claims and preauthorization submission procedures and Service departments. Some of the tools available for your use are:

HEALTHeNET
HEALTHeNET (wnyhealthenet.org) is an online community health information network established by an independently incorporated coalition of health insurance plans, including our plan and hospital providers. Some of the standard set of transactions available online are as follows:
Eligibility Transaction (270/271)
The eligibility transaction gives offices a direct connection to membership files and allows providers to confirm patients' eligibility in just minutes.
- The group size (small or large) is displayed on HEALTHeNET
- The month and day of each group's benefit renewal is displayed in the MMDD format. For example, June 1 is shown as 0601. This assists providers in determining when a member's benefit renews.

Claim Status Transaction (276/277)
This feature allows you to check the status of your claims. Providers are enabled able to obtain detailed information about claims, eliminating the need to contact the Provider Service Department.

Please go to wnyhealthenet.org to enroll. Additional tools are added to the website from time to time.

BlueCross BlueShield of Western New York Provider Website
Our website contains a variety of forms and information that will help you manage your practice. Online information includes:

- Provider referral form and instructions
- Provider request forms – BH OOP referral request, outpatient treatment reports
- Provider and Facility Reference Manual
- Quarterly newsletters
- Stat bulletins
- Billing guidelines
- Guideline for accessing autism benefits
Section 19 - Glossary

Access
The patient's ability to obtain medical care; the ease of access is determined by such components as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation and cost of care.

Accreditation
The process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined standards. Accreditation is usually given by a private organization created for the purpose of assuring the public of the quality of the accredited (such as the Joint Commission on Accreditation of Hospitals).

Acute Care
Health care delivered to patients experiencing an illness or health problem of a short-term or episodic nature. This term is used in contrast to the term "continuing care," which is often used to describe nursing homes or home health care.

Adjudication
Processing claims according to contract.

Adjustment
To make a correction on a claim or an account.

Administrative Services Organization (ASO)
A contract between an insurance company and a self-funded plan where the insurance company performs administrative services only and the self-funded entity assumes all risk.

Admission
Entry to a hospital as a patient, on an inpatient or outpatient basis.

Age Limit
Stated age(s) whereby eligibility for membership or benefits participation is determined.

Allowed Amount
Maximum dollar amount assigned for a procedure based on various pricing mechanisms, also known as a maximum allowable.

Ambulatory Care
Health services provided without the patient being admitted to a hospital. The services of ambulatory care centers, hospital outpatient departments, physicians' offices and home health care services fall under this heading.
Ancillary Services
Professional charges for x-ray, laboratory tests, and other similar patient services.

Average Generic Price (AGP)
The average reimbursement for medications that are off-patent and available from more than one manufacturer.

Average Wholesale Price (AWP)
The standardized cost of a pharmaceutical calculated by averaging the cost of an undiscounted pharmaceutical charged to a pharmacy provider by a large group of pharmaceutical wholesale suppliers.

Benefit
Refers either to a covered service under a particular contract or the dollar amount paid for a covered service.

Benefit Levels
The limit or degree of services a person is entitled to receive based on his/her contract with a health plan or insurer.

Benefit Package
Services an insurer, government agency, or health plan offers to a group or individual under the terms of a contract.

BlueCard® Program
A process that allows participating and BlueCross and/or BlueShield Plans to adjudicate claims for members who receive hospital or medical care from a participating facility/provider located outside of their Plan’s operating area.

Board Certified
Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

Board Eligible
Describes a physician who is eligible to take the specialty board examination by virtue of having graduated from an approved medical school, completing a specific type and length of training, and practicing for a specified amount of time.

Calendar Year
The period of time from January 1 of any year through December 31 of the same year; most often used in connection with deductible amount provisions of major medical plans providing benefits for expenses incurred within the calendar year. Also found in provisions outlining benefits in basic hospital, surgical, medical plans.
Capitation
A payment method in which a pre-determined amount is paid to a provider to deliver care to an individual; the payment is generally made monthly and the provider is responsible for the delivery of a specific range of health services for this set payment, regardless of actual cost of services.

Carrier
A company that sells insurance coverage or that markets prepaid health and medical coverage, such as a BlueCross and BlueShield Plan or an independent private insurance company.

Case Management
The process by which all health related matters of a case are managed by a physician, nurse or designated health professional. Physician case managers coordinate designated components of health care, such as appropriate referrals to consultants, specialists, hospitals, ancillary providers and other services. Case management is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the misutilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's needs over time.

Case Mix
The relative frequency and intensity of hospital admissions or services reflecting different needs and uses of hospital resources; case mix can be measured based on patients' diagnoses or the severity of their illnesses, the utilization of services, and the characteristics of a hospital.

Claim
A request for payment for health care services rendered.

CMS-1500
The standard form used by the Centers for Medicare and Medicaid Services for submitting physician service claims to third party (insurance) companies.

Coinsurance
A requirement under a health insurance contract by which the member shares a stated portion of his/her cost of care.

Comprehensive Major Medical Insurance
A policy designed to provide the protection offered by both a basic and major medical health insurance policy. It is generally characterized by a low deductible, a coinsurance feature, and high maximum benefits.

Concurrent Review
Utilization review activities conducted by insurers to determine the medical necessity and coverage of health care services, procedures, or treatments proposed to be rendered or being rendered to a member.
Confinement
An uninterrupted stay for a defined period of time in a hospital, skilled nursing facility or other approved health care facility or program followed by discharge from that same facility or program.

Contract Year
A period of 12 consecutive months, commencing with each anniversary date for member eligibility; may or may not coincide with a calendar year.

Coordination of Benefits (COB)
A clause in many insurance contracts that applies to group contract holders who have more than one contract covering the same services; a determination is made as to which contract is primary and which is secondary. The primary carrier pays first and any covered balances are then considered by the secondary carrier. The object is to guarantee that the insured is paid no more than the total charges when duplicate coverage exists, thereby eliminating the profit motive.

Copayment
A cost sharing arrangement in which the HMO enrollee pays a specified flat amount for a specific service. It does not vary with the cost of the service, unlike coinsurance, which is based on a percentage of cost.

CPT™ (Current Procedural Terminology)
A classification system developed by the American Medical Association in which unique codes are assigned to procedures and services (but not diagnoses) performed by providers.

Credentialing
A process of review to approve a provider who applies to participate in a health plan; specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan.

Custodial Care
The medical or non-medical services, which do not seek to cure, that are provided during periods when the medical condition of the patient is not changing, or do not require the continued administration by medical personnel. For example: assistance in the activities of daily living.

Date of Service
The date on which health care services were provided to the covered person.

Deductible
A dollar amount required to be paid by the insured under a health insurance contract, before benefits become payable.
Any covered charge that is incurred during October, November or December and is applied toward the deductible for that year, will also be carried over and applied to the following year's deductible.

Dependent
A person other than the contract holder who is covered under a contract.

Detoxification
Medical management while an individual withdraws from alcohol or chemical dependency.

Diagnosis
The identification of a disease or condition through analysis and examination.

Diagnosis Codes
See International Classification of Diseases (ICD-10).

Discharge Planning
The evaluation of a patient's medical needs in order to arrange for appropriate care after discharge from an inpatient setting.

Drug Formulary
A list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Organizations often develop a formulary under the guidance of a pharmacy and therapeutics committee. In HMOs, members may only have coverage for medications listed on a formulary.

Durable Medical Equipment (DME)
Products designed to help patients maintain maximum independence to continue living at home and to enhance the quality of life for both patients and caregivers.

Effective Date
The date a policy goes into effect.

Eligible
Qualified for coverage.

Emergency Care
Care for patients with severe or life-threatening conditions that require intervention within minutes or hours.

Exclusions
A provision in the contract stating situations or conditions under which coverage is not afforded; i.e., No Fault, Workers' Compensation.

Expedited Appeal
A process used for adverse determinations involving continued or extended health care services, procedures, or additional services for a continued course of treatment; or
when the provider believes an immediate appeal is warranted, except in the case of retrospective reviews.

Explanation of Benefits
A statement sent to a member that explains what action was taken on a claim.

Fee for Service
A method of payment that provides reimbursement, usually in pre-determined amounts, upon the occasion of the provision of a specific service; fee-for-service payments occur each time a service is rendered.

Fee Schedule
A listing of accepted fees or established allowances for specified medical procedures; as used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures.

Grievance Procedure
A grievance is a request to change a contractual determination other than a determination that a service is not medically necessary or is experimental of investigational. Examples of benefit determinations include denial of a referral or denial of coverage for a referred service, or any determination that a person is not eligible for coverage under the contract.

HCPCS (Health Care Procedure Coding System)
The Health Care Financing Administration’s Common Procedure Coding System, which includes the AMA's complete CPT™ and lists procedure codes for other categories of service such as durable medical equipment. HCPCS also includes a range of local codes for services not otherwise identified.

Health Maintenance Organization (HMO)
HMOs offer comprehensive health coverage for both hospital and physician services. HMOs contract with health care providers, e.g., physicians, hospitals, and other health professionals, and members are required to use participating providers for all health services. Model types include staff, group practice, network and IPA.

Healthcare Effectiveness Data and Information Set (HEDIS)
A set of performance measures designed to standardize the way health plans report data to employers. HEDIS currently measures five major areas of health plan performance: quality, access and patient satisfaction, membership and utilization, finance, and descriptive information on health plan management.

Hold Harmless Clause
A clause frequently found in managed care contracts whereby the HMO and the physician do not hold each other liable for malpractice or corporate malfeasance if either of the parties is found to be liable. Many insurance carriers exclude this type of liability from coverage. It may also refer to language that prohibits the provider from billing patients under certain circumstances. State and federal regulations may require this language.
Home Health Care
Full range of medical and other health related services such as physical therapy, nursing, counseling, and social services that are delivered in the home of a patient, by a provider.

Home Claims
Claims for a BlueCross BlueShield member who receives hospital or medical care from a participating provider of another BlueCross and/or BlueShield Plan.

Home Plan
A plan participating in the BlueCard® program whose member receives hospital and/or medical care in the area of another plan.

Hospice
A program of care that treats terminally ill patients and their families; the program, which is designed for patients with a prognosis of six months or less to live, provides coordinated, interdisciplinary inpatient and home care services, and emphasizes pain control and psychological well-being.

Hospital Affiliation
A contractual agreement between an HMO and one or more hospitals whereby the hospital provides the inpatient benefits offered by the HMO.

Host Claims
Claims for members of other BlueCross and/or BlueShield Plans who receive hospital or medical care from a participating provider of BlueCross BlueShield of Western New York.

Host Plan
A Plan participating in the BlueCard® Program that extends hospital and/or medical care to a BlueCross BlueShield member.

Identification Card
The card issued by the Plan as evidence of membership.

Identification Number
A unique number assigned to each member by the health plan.

Individual Practice Association (IPA)
A health care model that contracts with an individual practice association entity to provide health care services in return for a negotiated fee; the individual practice associations in turn contracts with physicians who continue in their existing individual or group practices. The individual practice association may compensate the physicians on a per capita, fee schedule, or fee-for-service basis.
Inpatient Care
Care given to a registered bed patient in a hospital, nursing home or other medical or post-acute institution.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
A system used to classify and code all diagnoses, symptoms, and procedures; is used to code and classify mortality data from death. ICD-10-CM is the replacement for ICD-9-CM, effective October 1, 2015.

Managed Care
A system of health care delivery that influences utilization of services, cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost-effective health care.

Medical Necessity
A service or treatment which is appropriate and consistent with diagnosis, and which, in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered.

Medicare
A Federal entitlement program created in 1965 that provides medical benefits to people over age 65, people who have received Social Security disability payments for more than two years, and people with end-stage renal disease.

National Committee for Quality Assurance (NCQA)
A nonprofit organization created to improve patient care quality and health plan performance in partnership with managed care plans, purchasers, consumers, and the public sector.

Out-of-Area (OOA)
A term describing the treatment obtained by a covered person outside the Plan's operating service area.

Out-of-Pocket Maximum
The total payments toward eligible expenses that a covered person funds for him/herself and/or his/her dependents: (deductibles, copays, and coinsurance) as defined per the contract. Once the maximum is reached, benefits will increase to 100 percent for health services received during the rest of that plan year. Some out-of-pocket costs (e.g. mental health, penalties for non-authorization, etc.) are not eligible for out-of-pocket limits.

Outlier
An inpatient stay that exceeds expected cost or length-of-stay thresholds and thereby becomes eligible for additional reimbursement under a prospective payment system.
Outpatient Care
Care given to a person who has not been admitted to the hospital.

Palliative Care
Care that is intended to relieve physical pain and address spiritual, psychological, and social needs, as opposed to contributing to a cure.

Patient Liability
The dollar amount that an insured individual is legally obligated to pay for services rendered by a provider.

Participating Provider
A provider who has entered into a contract with a health plan to provide medical care to covered members.

Payer
A government agency, insurer, or health plan that pays for health care services.

Peer Review
A mechanism used by medical staff to evaluate the quality of health care provided by the health plan. The evaluation covers how well services are performed by all health personnel and how appropriate the services are to meet patients' needs.

Per Member Per Month (PMPM)
A unit of measure used by HMOs for a variety of purposes, including capitation payment.

Place of Service
The location where a medical service was provided, such as inpatient hospital, outpatient hospital or doctor's office.

Point of Service Plan (POS)
Also known as an open ended HMO, POS plans encourage, but do not require, members to choose a primary care physician. As in traditional HMOs, the primary care physician acts as a "gatekeeper" when making referrals; plan members may, however, choose to visit non network providers at their discretion. Members choosing not to use the primary care physician must pay higher deductibles and copays than when using network physicians.

Preauthorization
A method of monitoring and controlling utilization by evaluating the need for medical service prior to it being performed.

Pre-existing Condition
A physical condition that existed prior to the effective date of a member's policy or enrollment in the Plan and may be subject to a limitation in the contract on coverage or benefits.
Preferred Provider Organization (PPO)
A managed care type of product that is offered by indemnity insurers or self-insured plans and provides enrollees the option of receiving services from participating or non-participating providers. The benefits packages are designed to encourage the use of participating providers by imposing higher deductibles and/or coinsurance for services provided by non-participating providers.

Primary Care Physician (PCP)
The PCP is the physician selected by the member and is responsible for monitoring the member's care and coordinating the delivery of all health care services.

Protected Health Information (PHI)
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), PHI is a term used to refer to individually identifiable health information that is transmitted electronically or maintained in any other form or medium.

Quality Assurance (QA)
Activities and programs intended to assure customers of the quality of care in a defined medical setting. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing its effectiveness and may measure care against pre-established standards.

Referral
The process of sending a patient from one practitioner to another for health care services; Health plans may require that designated primary care providers authorize a referral for coverage of specialty services.

Resource Based Relative Value Scale (RBRVS)
The classification system that is the basis for the Medicare physician fee schedule; the system assigns to physician services relative value units that incorporate resource consumption for 1) a work component that reflects the physician's skill and time required in furnishing the service, 2) a practice expense component that reflects general practice expenses, such as office rent and wages of personnel, and 3) a malpractice expense component.

Retrospective Review
Utilization review activities conducted by insurers to determine the medical necessity and coverage of health care services, procedures, or treatments that have already been provided to an enrollee.

Rider
A provision added to a contract that expands or limits the benefits that are otherwise payable.

Skilled Nursing Facility
A licensed institution as defined by Medicare that is primarily engaged in the provision of skilled nursing care.
Standard Appeal
A process where a provider or member can dispute an adverse decision based on medical necessity.

Stop Loss
A designated amount of eligible expenses that must be incurred by the member before payment can be made at 100 percent.

Stop Loss (Physicians)
A set dollar amount that is determined by the number of members within a physician's practice; if a member's health costs exceed this determined amount, the costs will be excluded from the calculation of the physician's actual per member per month expenditures.

Subacute Care
A level of care usually requiring a length of stay longer than short-term acute care and shorter than long-term skilled nursing care; an organized program of care for patients with either intense rehabilitative or medically complex needs, subacute care is focused on achieving specified measurable outcomes, using an interdisciplinary, case management approach, and providing care in an efficient and low-cost manner.

Subrogation
Means by which claims are identified as the responsibility of another insurer since treatment of the condition resulted from the action of an outside party.

Type of Service
Refers to services provided to a patient such as surgery, anesthesia, diagnostic x-ray, etc.

UB 04 Claim Form
Bill form used to submit hospital insurance claims for payment by third parties. Similar to CMS 1500 claim form, but reserved for inpatient and outpatient services.

Urgent Care
Medical care that requires prompt attention but is not life threatening (i.e. earache, rash, etc.)

Usual and Customary
A term used to describe the average charge for a service.

Utilization Management Review
A program designed to reduce the incidence of unnecessary or inappropriate use of hospital and/or doctor's services. It is used for both cost control and quality assurance.

Workers' Compensation
A state mandated program providing insurance coverage for work related injuries and disabilities.
Appendix 1: Medicare Advantage

Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO)

About This Section of the Manual

For your convenience, we have organized information pertaining exclusively to our Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) products in this separate section of the Provider Manual.

General Overview

HealthNow New York Inc. is the parent company of Buffalo-based BlueCross BlueShield of Western New York, and Albany-based BlueShield of Northeastern New York.

Senior Blue (HMO), BlueSaver (HMO) and Senior Blue Group (HMO-POS) are considered Medicare health maintenance organization (HMO) plans. Forever Blue (PPO) is the preferred provider organization product offered to Medicare eligible consumers.

These products provide quality, comprehensive health care services to people who are eligible for Medicare benefits either through disability or for those who are 65 years of age or older. As a Medicare HMO, Senior Blue (HMO), BlueSaver (HMO) and Senior Blue Group (HMO-POS) emphasize prevention, health maintenance and early diagnosis and treatment. Forever Blue (PPO) offers comprehensive benefits while also giving members the flexibility of choosing a provider from our network, obtaining specialist services without a referral, and the option to seek out-of-network care.

Provider Network

Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS) and Forever Blue (PPO) have contracted with hospitals and practitioners in Allegheny, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming counties. These providers are individually licensed or certified by the State to engage in the delivery of health care services, as well as entities engaged in the delivery of health care services. The providers were selected from our BlueCross BlueShield provider panel. All of our providers are credentialed when they enroll with BlueCross BlueShield and are re-credentialed every three years.

Senior Blue (HMO), BlueSaver (HMO) and Senior Blue Group (HMO-POS) members are required to select a primary care physician (PCP) from our directory of participating physicians. The PCP monitors his/her patients and coordinates the delivery of all health services, including preventive and routine medical care, hospitalization and specialized care.
Members are instructed to contact their PCP before seeking medical treatment, except in the case of a medical emergency, or when seeking out-of-area urgent care. This gives the PCP the opportunity to provide the member with the care he or she needs in the most appropriate manner.

Senior Blue Group (HMO-POS) members have the option to obtain care outside of the service area (out-of-network), through their Point-of-service (POS) benefit, for an additional cost. This excludes emergency or urgent care situations or for out-of-area rental dialysis, for which additional out-of-network cost does not apply. There is a limit to what our plan will cover under the Point-of-service (POS) benefit. Not all services are available under the POS benefit. Please reference the Evidence of Coverage (EOC) for more details.

The service area for Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) includes Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties in New York state.

The service area for Forever Blue 799 (PPO) includes all 50 states.

**Referrals and Preauthorization**

Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS) and Forever Blue (PPO) have a no-referral policy. However, if the member has or chooses to list a primary physician, it is important that the primary physician be responsible for monitoring and coordinating the delivery of all health care services, including preventive and routine medical care, hospitalization and specialized care for their patients.

Preauthorization must be obtained for all inpatient admissions and select outpatient procedures with a plan provider. These outpatient procedures are listed in current preauthorization guidelines found in our Stat Bulletins.

**Government Programs Provider Service**

BlueCross BlueShield Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS) and Forever Blue (PPO) products are serviced by a dedicated unit located in Buffalo, New York. Service Representatives are trained to assist you with claim questions. If you have a question regarding the status of a Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) claim or need an adjustment, please call 1-877-327-1395 or our TTY line for the hearing impaired at 711. Hours of operation are Monday to Friday, 8 a.m. to 5 p.m.

BlueCross BlueShield maintains the right to inspect, audit and evaluate all aspects of medical services furnished to Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) members. Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) providers must maintain all patient related records for at least ten years for audit purposes.
Statement of Cultural Diversity
BlueCross BlueShield recognizes the cultural diversity of our Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS) and Forever Blue (PPO) members. If you need assistance to meet the cultural needs of a member, the following are available:

- Toll-free TTY line for the hearing impaired 711
- The member may call the Government Programs Service Department for:
  - Assistance in contacting language or sign language interpreters through community services.
  - Assistance in identifying practitioners that speak a specific language (i.e., specialist that speaks Spanish).
  - Upon request, BlueCross BlueShield will make an interpreter available through the TransPerfect translator line for non-English speaking members free of charge. The member should direct his/her request to the Government Programs Customer Service Department at 1-800-329-2792. An interpreter will be located and connected to the call within minutes, free of charge.

Hours are 8 a.m. to 8 p.m. seven days a week, October 1 to March 31 and 8 a.m. to 8 p.m. Monday through Friday, April 1 to September 30.

Anti-Discrimination Policy
BlueCross BlueShield is committed to non-discriminatory behavior in conducting business with all of its members. All providers should have policies which demonstrate that they treat any member in need of health care services.

Product Overview
Senior Blue (HMO), BlueSaver (HMO), and Senior Blue Group (HMO-POS) are Medicare Advantage HMO plans. Senior Blue (HMO), BlueSaver (HMO), and Senior Blue Group (HMO-POS) plan options provide quality, comprehensive health care services to people who are eligible for Medicare, with an emphasis on prevention, health maintenance and early diagnosis and treatment. Senior Blue (HMO), BlueSaver (HMO) and Senior Blue Group (HMO-POS) are available to members who reside in Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming counties in New York State.

Senior Blue (HMO), BlueSaver (HMO) and Senior Blue Group (HMO-POS) are Medicare Advantage health plans with a Medicare contract offered by BlueCross BlueShield of Western New York. Applicants must be entitled to Part A, enrolled in Part B, and continue to pay any required Medicare premiums. All Medicare beneficiaries residing in the Senior Blue (HMO), BlueSaver (HMO), and Senior Blue Group (HMO-POS) service area may apply. Members must receive all routine and scheduled medical care from plan providers.

Senior Blue Group (HMO-POS) members also have the option to obtain care outside of the service area (out-of-network), through their POS benefit, for an additional cost. This
excludes emergency or urgent care situations or for out-of-area rental dialysis, for which additional out-of-network cost does not apply. There is a limit to what our plan will cover under the Point-of-service (POS) benefit. Not all services are available under the POS benefit. Please reference the Evidence of Coverage (EOC) for more details.

Beneficiaries who meet the eligibility requirements cannot be denied membership into the plan. Senior Blue (HMO), BlueSaver (HMO), and Senior Blue Group (HMO-POS) do not discriminate among Medicare beneficiaries based on health-related factors.

Please refer to the Senior Blue (HMO), BlueSaver (HMO), and Senior Blue Group (HMO-POS) Evidence of Coverage (EOC) for detailed information on covered services and copays.

Forever Blue (PPO) is our Medicare Advantage PPO plan option. Forever Blue (PPO) offers comprehensive benefits while also giving members the flexibility of choosing a provider from our network, obtaining specialist services without a referral, and the option to seek out-of-network care.

Forever Blue (PPO) is a Medicare Advantage health plan with a Medicare contract offered by BlueCross BlueShield of Western New York. Applicants must be entitled to Part A, enrolled in Part B, and continue to pay any required Medicare premiums. All Medicare beneficiaries residing in the Forever Blue (PPO) service area may apply. Forever Blue (PPO) plans are available to members who reside in Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming counties in New York State.

Beneficiaries who meet the Forever Blue (PPO) eligibility requirements cannot be denied membership in Forever Blue (PPO). Forever Blue (PPO) does not discriminate among Medicare beneficiaries based on health-related factors.

Please refer to the Forever Blue (PPO) Evidence of Coverage (EOC) for detailed information on covered services and copays.

**Opting-Out of Medicare**

Federal regulations prohibit Medicare Advantage (MA) organizations, including BlueCross BlueShield of Western New York, from paying for services rendered by physicians or practitioners who have chosen to opt out of the Medicare program, except in limited circumstances.

A MA organization may contract only with physicians or practitioners who are approved for participation in the Medicare program and who have not opted out of providing services to Medicare beneficiaries (See Social Security Act§ 42 CFR § 422.220). Opting out is not the same as "non-participating." Physicians or practitioners who opt out of Medicare cannot participate in our MA HMO and PPO networks.
BlueCross BlueShield will not cover any services provided by physicians/practitioners on or after the effective opt-out date, unless it is demonstrated that the service was eligible for payment as an emergency, or urgently needed under applicable Medicare standards.

Physicians and practitioners must follow the Centers for Medicare and Medicaid Services (CMS) rules regarding opting out of Medicare. Some of the rules could affect your business financially, such as the requirements under Social Security Act §1848 (g)(1) and/or 1848(g)(3).

CMS regulations for opt-out physicians or practitioners also require a "private contract" between the Medicare beneficiary and the physician or practitioner who opted out of Medicare. The private contract must include language such as, but not limited to, agreement that the Medicare beneficiary gives up Medicare payment - including payment from MA plans - for services furnished by the opt-out physician or practitioner, as well as to pay the physician/practitioner for services directly.

A physician or practitioner may cancel opt out by submitting written notice to the Medicare Administrative Contractor not later than 30 days before the end of the current two-year opt-out period. If a physician or practitioner wants an early termination of their opt-out status, there are specific Medicare requirements that must be met timely and the physician or practitioner must not have previously opted out. The requirements and possible exceptions concerning opting out are outlined in the CMS Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services. Chapter 15 can be accessed online at cms.gov/Regulations-and-Guidance/Guidance-Manuals/Internet-Only-Manuals-IOMs.html

If your status with Medicare changes, you must notify your Provider Network Management and Operations Specialist promptly at 1-800-666-4627.

More information regarding New York state physicians or practitioners who opt out of Medicare is available from the local Medicare Administrative Contractor, National Government Services, at ngsmedicare.com

**Senior Blue (HMO), BlueSaver (HMO), and Forever Blue (PPO) Plan Exclusions**

Any service not provided or arranged by a contracting medical provider, or prior authorized, (except for emergency or urgent care situations or for out-of-area renal dialysis) are not covered by Senior Blue (HMO) or BlueSaver (HMO).

Senior Blue Group (HMO-POS) members have the option to obtain care outside of the service area (out-of-network), through their POS benefit, for an additional cost. This excludes emergency or urgent care situations or for out-of-area renal dialysis, for which additional out-of-network cost does not apply. There is a limit to what our plan will cover under the Point-of-service (POS) benefit. Not all services are available under the POS benefit. Please reference the Evidence of Coverage (EOC) for more details.
Forever Blue (PPO) members may see medical providers that are not part of the network, but they will pay a higher cost-share.

In addition to any exclusions or limitations described in this manual, Chapter 4 of the member Evidence of Coverage (EOC) outlines additional plan level exclusions. This section is titled “What services are not covered by the plan”. These documents can be requested as needed by calling the plan.

Medical Protocols
Medical Protocols are available on our website. Unless separate Medicare Advantage criteria are listed in the protocol, the criteria indicated are applicable to services provided in the local Medicare Advantage operating area for Medicare Advantage members. This information in our protocols is designed to give you a concise, quick overview of the medical criteria we use to determine if a service is considered medically necessary under our Medicare Advantage contracts.

Outpatient Pharmacy Benefits
Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS) and Forever Blue (PPO) offer plans with a Medicare Part D Prescription Drug Benefit. Drugs administered or dispensed while the member is a patient in a hospital, nursing home, doctor’s office, outpatient clinic, or other institution are not covered under this benefit. The member, however, may be entitled to benefits under his or her basic medical contract.

With the Medicare Part D Prescription Drug benefit, physicians may prescribe drugs included on the BlueCross BlueShield Drug Formulary. The Drug Formulary promotes the safe and effective use of drug therapies by helping physicians select the drug product(s) considered most beneficial to their patient populations. The Formulary promotes rational, scientific prescribing based upon consideration of published clinical studies, data from the Food and Drug Administration (FDA), community standards, and cost/benefit evaluation.

The Formulary contains a listing of approved or preferred medications. It was developed and is maintained by our Pharmacy and Therapeutics (P&T) Committee. This committee consists of physicians, pharmacists, and other appropriate professional staff.

The goal of the Formulary is to improve the value of pharmaceutical care delivered through proper consideration of both quality-of-care and economic issues.

The P&T Committee evaluates and appraises the numerous pharmaceutical products available and makes recommendations to the Plan on those drugs considered to have the highest contribution to patient care. Through a continuous improvement process, the P&T Committee performs therapeutic drug class and product specific evaluations to maintain a clinically appropriate, cost-effective Formulary. Criteria such as efficacy, safety, risk/benefit ratio, therapeutic outcome, and cost are all included in the assessment process. Participating Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) providers are strongly encouraged to reference the Formulary before authorizing prescriptions for Senior Blue (HMO),
BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) members. For the latest pharmacy information, providers and members may visit our website at [bcbswny.com/medicare](http://bcbswny.com/medicare). Here you can click on “Rx drug information”, where you will find materials such as our drug formulary, monthly formulary changes, drug preauthorization requirements, step therapy guidelines, and our pharmacy quantity limits.

At the point of dispensing, the pharmacy will receive a message each time a non-Formulary medication is being filled. If you are the prescriber, the pharmacist may contact you prior to dispensing to discuss Formulary alternatives. Please consider the Appropriateness of Formulary treatment options for each patient. Many times a therapeutic switch can be made that will offer the patient the same outcomes to which they are accustomed.

**Utilization Management Program Overview**

The Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) Utilization Management Program is a dynamic process whose goal is to facilitate member health management throughout the continuum of care. The Program is tailored to meet the individual needs of our members. Our Care Management, Case Management, and Operations and Regulatory Compliance Units use an integrated process to help assure access to medical care for both members and providers.

For complete information regarding BlueCross BlueShield's Utilization Management Policies and Procedures please review Section 5 - Utilization Management.

**Health Care and Service Quality Improvement Program**

BlueCross BlueShield of Western New York recognizes the need for a comprehensive Health Care and Service Quality Improvement Program for our Medicare Advantage HMO and PPO products. We have initiated and carried out such a program in a manner designed to meet the goals and objectives of our Corporation.

The focus of the Health Care and Service Quality Improvement program is to assess and improve, on a continuous basis:

1. Care delivered by providers to members
2. Services delivered by Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) staff to members and
3. Health care and services rendered to Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) members in Western New York.

**Program Objectives**

- Assist in the Corporate Mission and Vision.
- Integrate quality improvement activities into corporate strategic plans and goals.
• Initiate and monitor activities and to correct quality/safety of care, access and service issues.
• Identify best practices through review of structure, process and outcomes.
• Report quality assessment information and make recommendations regarding participation and continued participation of providers according to the approved credentialing process.
• Develop, implement and evaluate for effectiveness the opportunities to improve quality of care and services.
• Distribute quality improvement activity findings as part of a Quality Improvement Process (QIP) or Problem Solving Process (PSP).
• Sponsor and support interdepartmental quality improvement activities.
• Promote a high standard of care through analysis of clinical and service practices.
• Adopt national (or regional if more stringent) standards, criteria and benchmarks for health care quality improvement activities.
• Serve as a resource to providers, supplying consultation and education related to implementation of the Quality Improvement programs.
• Provide a leadership role in health improvement programs, utilizing preventive care guidelines, best practice and clinical quality measures.
• Educate providers and members toward improving their health and health care meet and exceed all requirements for regulatory and accreditation oversight (CMS, NYS DOH/DFS, NCQA, and BCBSA).
• Identify areas of the health care provided to our members that require improvement and take corrective action.

Scope
The scope of the Health Care Quality Improvement Program is comprehensive. It includes all Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) members, as well as providers and practitioners who participate on these provider panels. Expansion areas will be included in all Quality Improvement initiatives.

The Health Care Quality Improvement Program includes organizational wide activities, a focus on trend analysis, and development of interventions that improve the quality of care and service provided to our members.

The Health Care Quality Improvement Program monitors and evaluates a wide variety of clinical and service topics for Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) members that include, but are not limited to, those listed below.

Clinical Topics
• Health Promotion
• Preventive Care
• Disease Management
• Case Management-coordination of care
• 24-hour health information line
• Utilization Management (including appropriate utilization of services)
• Patient Safety
• Behavioral Health Management
• Culturally and Linguistically Appropriate Services
• Complaint management for access to care or quality of care issues
• Medical policy
• Pharmacy Management
• Continuity and Coordination of Care

Service Topics
• Accurate and timely phone responses
• Access to practitioners and providers
• Satisfaction/dissatisfaction issues identified through satisfaction surveys, complaints, PCP change requests
• Information regarding managed care processes, such as competence of staff, attitude of representatives, times of operation and efficiency of Public Health Goals Integration

Public Health Goals Integration
The Health Care Quality Improvement Program for our Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) products include, whenever possible, integration of Public Health goals. In particular:
• Healthy People 2020 goals are used in planning and evaluating progress on clinical issues.
• HEDIS®, QARR, and Quality Rating System (QRS) results, etc. where appropriate
• Staff interacts with local and state Public Health Department staff to address issues of local special populations such as Medicaid recipients, children and the elderly
• Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS) and Forever Blue (PPO) utilize reports and data from Public Health Sources in evaluating the needs of the membership, the population in general and service areas covered.
• Staff actively participates in collaborations with community task forces and initiatives to improve the health status of the Western New York community (such as smoking cessation coalitions, physical activity task forces, health risk appraisals for Western New York counties, etc.)

Claims Submission

See Section 13 for electronic claim submission information.
All adjustments and/or correspondence for Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) should be submitted to the following address:

BlueCross BlueShield of Western New York
PO Box 80
Buffalo, NY 14240

The following abbreviation will appear on your payment voucher to indicate the contract type:
SB – Senior Blue (HMO) and BlueSaver (HMO)  
MPPO – Forever Blue (PPO)

This abbreviation will appear in the Line of Business (LOB) code field. Claims will be processed and paid in accordance with CMS Prompt Pay guidelines.

For further information regarding billing and/or claims submission, please refer to the Claims/Billing Information Section of your Physician Manual.

**Reimbursement**

Senior Blue (HMO), BlueSaver (HMO) and Senior Blue Group (HMO-POS)  
Reimbursement for covered services will be made according to the Senior Blue (HMO), BlueSaver (HMO), and Senior Blue Group (HMO-POS) fee schedule. For authorized services provided by a non-participating Senior Blue (HMO), BlueSaver (HMO), or Senior Blue Group (HMO-POS) physician, payment will be made according to Medicare reimbursement policies.

Forever Blue (PPO)  
Reimbursement for covered services will be made according to the Forever Blue (PPO) fee schedule. For authorized services provided by a non-participating Forever Blue (PPO) physician, payment will be made according to Medicare reimbursement policies.

Concierge or Boutique Medicine  
Participating physicians, suppliers, and providers who consider charging Medicare patients additional fees should be mindful that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance.

If you have additional questions regarding payment for services rendered to Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), or Forever Blue (PPO) members, please refer to your Participating Provider Agreement.

**Member ID Card**  
Members may not receive an identification card prior to their effective date of coverage. A proposed effective date letter and a copy of the enrollment application are mailed to the member while BlueCross BlueShield is processing the member's application. The enrollment application and/or effective date letter should be used by providers as proof of enrollment in lieu of an ID card.

To verify a member's eligibility, please call our Government Programs Member Service Department at 1-800-329-2792 (TTY 711). Hours of operation are 8 a.m. to 8 p.m. seven days a week, October 1 to March 31 and 8 a.m. to 8 p.m. Monday through Friday, April 1 to September 30.
Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) members will receive a member ID card. Patients should be asked to present their ID card at the time of service to assist in:

- checking eligibility
- obtaining copayment information
- coordinating admissions
- delivering service
- filing claims

Possession of a member ID card does not guarantee eligibility for benefits, coverage or payment. Please verify eligibility status at the time of delivery of service or admission to a hospital or other facility.

Members enrolled in Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), or Forever Blue (PPO) will have both a BlueCross BlueShield ID card and their Medicare card. A Medicare ID card alone is not proof of eligibility.

**Member Rights and Responsibilities**

BlueCross BlueShield members that have selected our Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), or Forever Blue (PPO) health plan options have certain rights to help protect them and responsibilities that we ask they assume. We have included an abridged version of the Member Rights and Responsibilities document below. Also included is a copy of our policy regarding Perceived Denials. We encourage all of our participating Medicare Advantage providers to review these policies and become familiar with them.

**Perceived Denials**

We recognize, appreciate, and support your efforts to manage the care of your Medicare Advantage patients in a prudent, cost-effective manner. However, the Centers for Medicare and Medicaid Services (CMS) require that when a member perceives a denial of treatment or care, he/she is entitled to certain appeal rights under Federal Law. This includes situations in which the member's request is made directly to the provider and one of the following conditions exists:

- The member disagrees with your prescribed course and/or type of treatment.
- You decline to provide a course of treatment and/or type of treatment that the member is requesting.
- You discontinue a course of treatment or reduce a course of treatment.

**Examples of Denial**

Some examples of a perceived denial are:

- A patient asks to be referred to a radiologist for a MRI but you feel that a MRI is not necessary.
A new prescription drug comes out on the market and one of your patients would like you to prescribe it for him/her. You decline to write the prescription at the present time because the American Medical Association and the Food and Drug Administration have not yet approved the drug for use in the senior population.

A patient asks to be referred to a dermatologist for the treatment of a rash. You decline to refer the patient because you can effectively treat him/her yourself.

A patient is receiving physical therapy services and you determine that physical therapy is no longer necessary.

Your Responsibility

When a perceived denial occurs, the following must take place:

- You must contact the Utilization Management Department, the day that the denial occurs, at 1-800-677-3086 to apprise BlueCross BlueShield of the situation. It is your responsibility to ensure that our members are informed of their right to appeal.

- We will then issue a letter stating the details of the denial, including a description and reason for the denial. The letter will inform the member of the clinical rationale, as well as the right to obtain reconsideration and the procedure for requesting reconsideration. You will receive a copy of this letter, at the same time the letter is sent to the member.

- The member will be advised that he/she can appeal if they do not agree with our decision about their health care.

If you have any questions about perceived denials, contact Utilization Management at 1-800-677-3086.

Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS) and Forever Blue (PPO) Appeals Process

The member is entitled to certain appeal rights under Federal Law pertaining to disputes involving an initial organization determination, denial of services, or payment.

All disputes involving initial adverse organization determinations are handled through the Medicare Appeals process. There is a Standard Appeals Process and an Expedited Appeals Process. The Expedited Appeals Process addresses adverse initial organization determinations, which could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

There are five levels of appeal:

- Level I Reconsideration Request Determination
- Level II IRE Reconsideration
- Level III Administrative Appeal (Administrative Law Judge)
- Level IV Appeals Council
- Level V Federal Court
Level I appeal
A Level I appeal is a reconsideration request of the adverse initial organization determination, whether standard or expedited. A clinical peer reviewer who has not made the initial determination makes a Level I appeal decision. In the context of adverse determination appeals, a clinical peer reviewer is a licensed physician who is in the same or similar specialty as the health care provider who typically manages the medical condition, procedure, or treatment under review.

Level II appeal
If a Level I denial is upheld, whether payment or services, the entire case is forwarded to the Independent Review Entity (IRE) Reconsideration for a Level II Appeal review.

Level III appeal
Any party to the reconsideration (except BlueCross BlueShield) dissatisfied with the reconsideration decision has a right to a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration.

Level IV appeal
Any party dissatisfied with the decision of the ALJ (including BlueCross BlueShield) may request the Medicare Appeals Council (MAC) to review the ALJ's decision or dismissal.

Level V appeal
A right to a Judicial Review of an ALJ decision may be requested only if the MAC has acted on the case. A party to the hearing (including BlueCross BlueShield) may request judicial review of an ALJ or MAC decision.

Standard appeal
Deadline for requesting an appeal: A member may request an appeal of an adverse determination in writing within 30 days for pre service and 60 days for post service after receiving notification of the adverse determination.

The following may file a request for reconsideration:

- Member
- Legal representative of a deceased member’s estate
- The authorized representative of a member (representative form must be completed).

Procedure for conducting a standard appeal:
1. BlueCross BlueShield requests pertinent medical records from the provider if they have not already been submitted.
2. If the member's health could be in jeopardy, the expedited review process is implemented. BlueCross BlueShield also may extend the time frame by up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee.
3. BlueCross BlueShield is responsible for processing standard appeals within 30 days for pre service and 60 days for post service from the date request is received. The determination of an appeal on a clinical matter will be made by
personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination.

4. If the decision is to uphold the original denial, the entire case must be sent to the Independent Review Entity (IRE). The IRE will make a reconsideration decision on clean cases within 30 days and claim reconsiderations within 60 days and will advise the member of that decision in writing. If the decision is not wholly favorable to the member, the notice will include the member's right to a hearing before an Administrative Law Judge of the Social Security Administration.

**Expedited appeal**

Eligibility for expedited appeal:
Request for an expedited appeal may be made by telephone or in writing. There is an established process for making reconsideration determinations when the life or health of a member or a member's ability to regain maximum function could be seriously jeopardized by waiting 30 days for a standard reconsideration determination.

A request for an Expedited Appeal may come from a physician, if the physician has been designated as the member's representative (The "Appointment of Representative Form" must be completed), or a member. Any request from a member must first be reviewed to ensure that it meets the criteria for an Expedited Appeal. The member or physician may state that they want an "Expedited Appeal", a "fast appeal" or a "72-hour appeal." These terms are all synonymous and imply an expedited review other than the standard 30 day appeal process.

Procedure for conducting an expedited appeal:
- BlueCross BlueShield requests pertinent medical records from the provider if they have not already been submitted.
- BlueCross BlueShield makes a determination with regard to the expedited appeal within 72 hours of receipt of the appeal. The determination of an appeal on a clinical matter is made by personnel qualified to review the appeal, including licensed, certified, or registered health care professionals who did not make the initial determination.
- If the decision is to uphold the original denial, the entire case must be sent to the Independent Review Entity (IRE). The IRE will make a reconsideration decision within 72 hours and will advise the member of that decision in writing. If the decision is not wholly favorable to the member, the notice will include the member's right to a hearing before an Administrative Law Judge of the Social Security Administration.
- Failure to comply with timeframes for an internal appeal of a utilization review determination is deemed a reversal of the initial determination.

**Advance Directives**

BlueCross BlueShield is required by law to inform our members of their right to make health care decisions and to execute advance directives regarding their care. An
advance directive is a formal document, written by the member in advance of an incapacitating illness or injury. As long as the BlueCross BlueShield member can speak for him/her self, contracting BlueCross BlueShield medical providers must honor the member's wishes. In the event that an incapacitating illness prevents the member from being able to make his or her own health care decisions, then the advance directive will guide the BlueCross BlueShield provider to provide treatment according to the member's wishes. Members who complete the advance directive will spare caregivers the task of making difficult treatment decisions without prior knowledge of what the member would have wanted.

All participating BlueCross BlueShield providers should obtain, and keep on file, advance directives that clearly outline a member's wishes in the event that a serious illness or injury should occur. Advance directives may be obtained by having the member complete a Health Care Proxy, Do Not Resuscitate Order (DNR) or Living Will. Many providers have found it helpful to add advanced directives to the preventive health checklist and to the initial/annual visit routines.

Health Education and Preventive Care

Health Education and Preventive Care are important in keeping your patients healthy. That is why we offer the Community Wellness Program, with more than 250 health education programs to choose from. The Community Wellness Program offers your patients a wide variety of health resources, free of charge. Patients do not require a referral or written approval for most approved classes.

At the present time, classes are primarily offered in the following categories:

- Asthma
- Arthritis
- Children and adolescent health
- Diabetes education
- Heart health
- Injury prevention and self-care
- Maternal and infant health
- Nutrition
- Physical activity
- Senior health
- Smoking cessation
- Stress management
- Weight management

You or your patients may view a current list of programs by visiting the Health & Wellness section for members on our website bcbswny.com.

Preventive Health Guidelines
Prevention and Screening programs are important. Senior Blue (HMO), BlueSaver (HMO), Senior Blue Group (HMO-POS), and Forever Blue (PPO) practitioners will
receive notice in the provider newsletter when the Preventive Health Guidelines are updated. Physicians serving on our Quality Management Committee approve these guidelines. We urge you to encourage your patients to receive these important screening tests. To assist you in this effort, we have developed several programs targeted to our senior population, e.g., breast and colorectal cancer screening reminders and flu shot and pneumonia vaccine awareness campaigns.

Health Management Programs

The goal of health management programs is to improve the quality of life for patients. Health management employs a team effort to assist the primary care physician with patient management, particularly those patients with serious or chronic medical problems. Instead of the traditional component management system, health management incorporates a systems approach to improving patient outcomes by effectively coordinating all elements of health care delivery.

Through health management programs, we can examine physician practice patterns and patient compliance with treatment recommendations. By documenting these variables, we can determine how well current treatments are working for patients in every day practice. The relationship between treatment and patient outcomes is usually studied through controlled clinical trials that randomly assign patients to different treatments, thereby assuring similarity of patients across treatments when comparing outcomes.

However, in Health Management Programs, we measure what happens to patients in everyday practice. Patients receiving different treatments are generally not comparable -- those who are sicker receive more intensive treatment. The goal of each health management program is to answer the question: "How do we provide the best treatment to every patient with this condition, thus assuring the best possible health outcomes?"

To assist physicians in caring for patients with serious chronic medical problems, BlueCross BlueShield has implemented planned health management programs for the following:
- Asthma Program
- Attention Deficit Hyperactivity Disorder (ADHD) Program
- Behavioral Health Case Management
- Cardiovascular Management Program (includes CAD and CHF)
- Case Management Program (includes oncology, chronic kidney disease)
- COPD Management Program
- Depression Management Program
- Diabetes Management Program
- Hip and Knee Program
- Obstructive Sleep Apnea Program
- Palliative Care Program
- Right Start High-Risk Prenatal Program
- Spine Health Management Program
- Substance Use Disorder Program
Appendix 2: BlueCard® Program

The BlueCard® Program Provider Manual

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Section 6 - BlueCard® Program Quick Tips

Introduction

The BlueCard® Program makes filing claims easy.

As a participating provider of BlueCross BlueShield of Western New York you may render services to patients who are national account members of other Blue Plans, and who travel or live in our service area.

This manual is designed to describe the advantages of the program, while providing you with information to make filing claims easy. This manual will offer helpful information about:

1. Identifying members
2. Verifying eligibility
3. Obtaining precertification/preauthorization
4. Updating your provider information
5. Filing claims
6. Who to contact with questions.
Section 1 - What is the BlueCard® Program?

BlueCard is a national program that enables members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan’s service area.

The program links participating health care providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program allows you to submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Your local Blue Plan is your sole contact for claims payment, problem resolution and adjustments.

BlueCard® Program Advantages
The BlueCard Program allows you to conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to BlueCross BlueShield of Western New York.

BlueCross BlueShield of Western New York will be your one point of contact for all of your claims-related questions. More than 79,000 other Blue Plans’ members are currently residing in our service area. BlueCross BlueShield of Western New York continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations. In doing so, your patients will have a positive experience with each visit.

Products included in BlueCard
A variety of products and claim types are eligible to be delivered via BlueCard, however not all Blue Plans offer all of these products to their members. Currently, BlueCross BlueShield of Western New York offers products indicated by the bullets below, however you may see members from other Blue Plans who are enrolled in the other products.

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization)
- POS (Point of Service)
- HMO (Health Maintenance Organization)
  HMO claims are eligible to be processed under the BlueCard Program or through the Away from Home Care program
- BlueCard Worldwide Program claims
- Medigap – Medicare Complementary / Supplemental
- Medicaid: Payment is limited to the member’s Plan’s state Medicaid reimbursement rates; these cards will not have a suitcase logo
- Stand-Alone SCHIP (State Children’s Health Insurance) if administered as part of Medicaid: Payment is limited to the member’s Plan’s state Medicaid
reimbursement rates. These member ID cards also do not have a suitcase logo. Standalone SCHIP programs will have a suitcase logo

- Medicare Advantage
- Senior Blue
- Standalone vision
- ASO (Administrative Services Only)

Note: Standalone vision and standalone self-administered prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim flinging instructions on the back of the ID cards.

**Accounts Exempt from the BlueCard Program**

The following Claims are excluded from the BlueCard Program:

- Stand-alone Dental
- Prescription Drugs
- Claims for the Federal Employee Program (FEP) are exempt from the BlueCard Program; please follow your FEP billing guidelines
Section 2 - How the BlueCard Program Works

In the example above, a member has PPO coverage through BlueCross BlueShield of Tennessee. There are two scenarios where that member might need to see a provider in another Plan’s service area, in this example, Illinois:

1. if the member was traveling in Illinois or
2. if the member resided in Illinois and had employer-provided coverage through BlueCross BlueShield of Tennessee

In either scenario, the member can obtain the names and contact information for BlueCard PPO providers in Illinois by calling the BlueCard Access Line at 1.800.810.BLUE (2583). The member also can obtain information on the Internet, using the BlueCard National Doctor and Hospital Finder available at bcbs.com.

NOTE: members are not obligated to identify participating providers through either of these methods but it is their responsibility to go to a PPO provider if they want to access PPO in-network benefits.

When the member makes an appointment and/or sees an Illinois BlueCard PPO provider, the provider may verify the member’s eligibility and coverage information via the BlueCard Eligibility Line at 1.800.676.BLUE (2583). The provider also may obtain this information via a HIPAA electronic eligibility transaction if the provider has established electronic connections for such transactions with the local Plan, Blue Cross and Blue Shield of Illinois.

After rendering services, the provider in Illinois files a claim locally with Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield of Illinois forward the claim to BlueCross BlueShield of Tennessee that adjudicates the claim according to the member’s benefits and the provider’s arrangement with the Illinois Plan. When the claim
is finalized, the Tennessee Plan issues an explanation of benefit or EOB to the member, and the Illinois Plan issues the explanation of payment or remittance advice to its provider and pays the provider.

**How to Identify Members**

**Member ID Cards**

When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifier for out of area members is the prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo
- No suitcase

**Important facts concerning member IDs:**

- A correct member ID number includes the - prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numbers/letters following the prefix.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- The prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Members who are part of the Federal Employee Program (FEP) will have the letter "R" in front of their member ID number. Claims for these members should also be filed with the local/Host Plan.

Examples of ID Numbers:

```
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC1234H567</td>
<td>A2C12345678901234</td>
</tr>
<tr>
<td>Prefix</td>
<td>Prefix</td>
</tr>
</tbody>
</table>
```

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in the member’s file.
- Verify with the member that the ID number on the card is not his/her Social Security Number. If it is, call the BlueCard Eligibility line 1.800.676.BLUE (2583) to verify the ID number.
- Make copies of the front and back of the member’s ID card and pass this key information on to your billing staff.
• Remember: member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers.

Prefix
The three-character prefix, at the beginning of the member's identification number, is the key element used to identify and correctly route claims. The prefix identifies the Blue Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage. To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card, and pass this key information to your billing staff.

• Do not make up prefixes.
• Do not assume that the members ID number is the social security number. All Blue Plans replaced Social Security numbers on member ID cards with an alternate, unique identifier.
Sample ID Cards

BlueCard ID cards have a suitcase logo, either as an empty suitcase or as a PPO in a suitcase.

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to BlueCross BlueShield of Western New York PPO provider contract. Please note that EPO products may have limited benefits out-of-area. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.
The empty suitcase logo indicates that the member is enrolled in one of the following products: Traditional, HMO or POS. For members having traditional coverage, you will be reimbursed according to BlueCross BlueShield of Western New York traditional provider contract. For members who have HMO and POS coverage, you will be reimbursed according to BlueCross BlueShield of Western New York Managed Care provider contract.

Some Blue ID cards don’t have any suitcase logo on them, such as the ID cards for Medicaid, State Children’s Health Insurance Programs (SCHIP) if administered as part of State’s Medicaid, and Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products.

Tip: While BlueCross BlueShield of Western New York routes all of these claims for out-of-area members to the member’s Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member’s Blue Plan via the established electronic Medicare crossover process.

**How to Identify BlueCard Managed Care**
The BlueCard Managed Care program is for members who reside outside their Blue Plan’s service area. Unlike the BlueCard PPO Program, the BlueCard Managed Care members are enrolled in BlueCross BlueShield’s network and primary care physician (PCP) panels. You can recognize BlueCard Managed Care members who are enrolled in BlueCross BlueShield’s network through the member ID card as you do for all other BlueCard members. The ID cards will include:

- A local network identifier and
- The three-character prefix preceding the member’s ID number
- The blank suitcase logo

For members who participate in the BlueCard POS coverage, you will be reimbursed according to BlueCross BlueShield of Western New York Managed Care provider contract, if you participate in the BlueCard POS voluntary program.

If you are unsure about your participation status, call BlueCross BlueShield of Western New York.
Sample ID Card:

![Sample ID Card Image]

**How to Identify International Members**

Occasionally, you may see identification cards from members of international licensees. Currently, those licensees include Blue Cross Blue Shield of the U.S. Virgin Islands, BlueCross & BlueShield of Uruguay, Blue Cross and Blue Shield of Panama, Blue Cross Blue Shield of Costa Rica and GeoBlue, but if in doubt, always check with BlueCross BlueShield of Western New York as the list of International Licensees may change. ID cards from these Licensees will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and file their claims to BlueCross BlueShield of Western New York.

**Example of an ID Card from an International Licensee:**

![Example ID Card Image]
Examples of ID cards for International Products

Illustration A - GeoBlue:

Illustration B – Blue Cross Blue Shield Global Core portfolio:

Illustration C – Shield-only ID Card:

Please note: in certain territories, including Hong Kong and the United Arab Emirates, Blue Cross branded products are not available. The ID cards of members in these territories will display the Blue Shield Global Core logo (see example below):
Canadian ID Cards

Please note: The Canadian Association of Blue Cross Plans and its member plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member Plans in the United States.

You may occasionally see ID cards for people who are covered by a Canadian Blue Cross plan. Claims for Canadian Blue Cross plan members are not processed through the BlueCard® Program.

Please follow the instructions of the Blue Cross plans in Canada and those, if any, on the ID cards for servicing their members. The Blue Cross plans in Canada are:

- Alberta Blue Cross
- Manitoba Blue Cross
- Medavie Blue Cross
- Ontario Blue Cross
- Pacific Blue Cross
- Quebec Blue Cross
- Saskatchewan Blue Cross

Source: http://www.bluecross.ca/en/contact.html

Consumer Directed Health Care and Health Care Debit Cards

Consumer Directed Health Care (CDHC) is a term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information and financial incentives.

Members who have Consumer Directed Health Care (CDHC) plans often have healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). All three are types of tax favored accounts offered by the member’s employer to pay for eligible expenses not covered by the health plan.

Some cards are “stand-alone” debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

- Reduce bad debt
- Reduce paperwork for billing statements
- Minimize bookkeeping and patient account functions for handling cash and checks
- Avoid unnecessary claim payment delays

In some cases, the card will display the Blue Cross and Blue Shield trademarks, along with the logo from a major debit card such as MasterCard® or Visa®.

Below is a sample stand-alone health care debit card:
Below is a sample combined health care debit card and member ID card:

The cards include a magnetic strip allowing providers to swipe the card to collect the member’s cost-sharing amount (i.e., copayment). With healthcare debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the member’s appropriate HRA, HSA or FSA account.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as what you pay to swipe any other signature debit card.

Helpful Tips:

- Using the member's current member ID number, including prefix, carefully determine the member’s financial responsibility before processing payment. Check eligibility and benefits electronically through BlueCross BlueShield of Western New York or by calling 1.800.676.BLUE (2583).
- All services, regardless of whether or not you’ve collected the member responsibility at the time of service, must be billed to BlueCross BlueShield of Western New York or proper benefit determination, and to update the member’s claim history.
- Please do not use the card to process full payment up front. If you have any questions about the member’s benefits, please contact 1.800.676.BLUE (2583) or, for questions about the health care debit card processing instructions or payment...
issues, please contact the toll-free debit card administrator’s number on the back of the card.

Limited Benefit Products
Verifying Blue patients’ benefits and eligibility is important, now more than ever. Since new products and benefit types entered the market. Patients who have traditional Blue PPO, HMO, POS, or other coverage, typically with high lifetime coverage limits i.e. ($1 million or more) and you may now see patients whose annual benefits are limited to $50,000 or less.

Currently BlueCross BlueShield of Western New York doesn’t offer such limited benefit plans to our members, however you may see patients with limited benefits who are covered by another Blue Plan.

How to recognize members with limited benefits products?
Members with Blue limited benefits coverage (that is, annual benefits limited to $50,000 or less) carry ID cards that may have one or more of the following indicators:

- Product name will be listed such as InReach or MyBasic
- A green stripe at the bottom of the card
- A statement either on the front or the back of the ID card stating this is a limited benefits product
- A black cross and/or shield to help differentiate it from other identification cards

These ID cards may look like this:
How to find out if the patient has limited benefit coverage?
You may do so electronically by submitting HIPAA 270 eligibility inquiry to BlueCross BlueShield of Western New York at bcbswny.com or via an Electronic Data Interchange (EDI) transaction or 1.800.676.BLUE (2583) eligibility line for out-of-area members.

Both electronically and via phone, you will receive patient’s accumulated benefits to help you understand the remaining benefits left for the member.

- **Tips:** In addition to obtaining a copy of the member’s ID card, regardless of the benefit product type, always verify eligibility and benefits electronically with BlueCross BlueShield of Western New York or by calling 1-800-676-BLUE (2583). You will receive the member’s accumulated benefits to help you understand his/her remaining benefits.

- If the cost of service extends beyond the member’s benefit coverage limit, please inform your patient of any additional liability he/she might have.

- If you have questions regarding a Blue Plan’s limited benefits ID card/product, please contact The number on the members ID card

What should I do if the patient’s benefits are exhausted before the end of their treatment?
Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatment are member’s liability.

Who do I contact if I have additional questions about Limited Benefit Plans?
If you have any questions regarding any other Blue Plans’ Limited Benefits products, contact BlueCross BlueShield of Western New York at 1-800-444-2012.

Reference Based Benefits
With health care costs increasing, employers are considering alternative approaches to control health care expenses by placing a greater emphasis on employee accountability by encouraging members to take a more active role while making health care decisions. Plans have begun to introduce Reference Based Benefits, which limit certain (or specific) benefits to a dollar amount that incents members to actively shop for health care for those services.

The goal of Reference Based Benefits is to have members engage in their health choices by giving them an incentive to shop for cost effective providers and facilities. Reference Based Benefit designs hold the member responsible for any expenses above a calculated “reference cost” ceiling for a single episode of service. Due to the possibility of increased member cost sharing, Reference Based Benefits will incent members to use Plan transparency tools, like the National Consumer Cost Tool (NCCT), to search for and identify services that can be performed at cost effective providers and/or facilities that charge at or below the reference cost ceiling.
How do reference-based benefits work?
Reference-based benefits are a new benefit feature where the plan will pay up to a pre-
determined amount for specific procedures called a “reference cost.” If the allowed
amount exceeds the reference cost, that excess amount becomes the members’
responsibility.

How are reference costs established?
The reference costs are established for an episode of care based on claims data
received by BlueCross BlueShield of Western New York from providers in your area.

How will I get paid?
Reference Based Benefits will not modify the current contracting amount agreed on
between you and BlueCross BlueShield of Western New York. Providers can expect to
receive their contract rate on all procedures where Reference Based Benefits apply.

• Example 1: If a member has a reference cost of $500 for an MRI of the spine and
  the allowable amount is $700, then BlueCross BlueShield of Western New York
  will pay up to the $500 for the procedure and the member is responsible for the
  $200.

• Example 2: If a member has a reference cost ceiling of $600 for a CT scan of the
  Head/Brain and allowable amount is $400, then BlueCross BlueShield of
  Western New York will pay up to the $400 for the procedure.

How much will the member be responsible for out-of-pocket?
When reference-based benefits are applied and the cost of the services rendered is less
than the reference cost ceiling, then BlueCross BlueShield of Western New York will
pay eligible benefits as it has in the past; while the member continues to pay their
standard cost sharing amounts in the forms of: co-insurance, co-pay, or deductible as
normal.

If the cost of the services rendered exceeds the reference cost ceiling, then BlueCross
BlueShield of Western New York will pay benefits up to that reference cost ceiling, while
the member continues to pay their standard cost sharing amounts in the forms of: co-
insurance, co-pay, or deductible; as well as any amount above the reference cost
ceiling up to the contractual amount.

How will I be able to identify if a member is covered under reference-based
benefits?
When you receive a response from a benefits and eligibility inquiry, you will be notified if
a member is covered under reference-based benefits.

Additionally, you can call the Blue Eligibility number (1-800-676-2583) to verify if a
member is covered under reference-based benefits.
Do I need to do anything different if a member is covered under reference-based benefits?
While there are no additional steps that you need to take, you may want to verify the reference cost maximum prior to performing a procedure covered under Reference Based Benefits. You can check if reference-based benefits apply to professional and facility charges for the member, by submitting an electronic a benefits and eligibility inquiry to your local Blue Plan. Alternatively, you can contact the member’s Plan by calling the Blue Eligibility number (800-676-2583).

Do reference-based benefits apply to emergency services?
No. Reference-based benefits are not applicable to any service that is urgent or emergent.

Do reference-based benefits apply to benefits under the Affordable Care Act essential health benefits?
Yes. Health plans must offer products at the same actuarial value to comply with the Affordable Care Act legislative rules.

How does the member identify services at or below the reference cost?
Members with reference-based benefits use consumer transparency tools to determine if a provider will deliver the service for less than the reference cost.

How will the reference-based benefits cost apply to professional and facility charges?
For more information on how reference-based benefits will apply costs to the professional and facility charges, please submit an electronic benefits and eligibility inquiry to the member’s local Blue plan. If you have additional questions, you can contact the Blue Eligibility number (1-800-676-2583) for the member you are seeing.

What if a member covered under reference-based benefits asks for additional information about their benefits?
Since members are subject to any charges above the reference cost up to the contractual amount for particular services, members may ask you to estimate how much a service will cost.
Also, you can direct members to view their Blue plans transparency tools to learn more about the cost established for an episode of care.

What procedures are covered under reference-based benefits?
The following procedures will be covered under reference-based benefits:

* Applicable services may vary by employer group.

Where do I submit the claim?
You should submit the claim to BlueCross BlueShield of Western New York under your current billing practices.
How will reference-based benefits be shown on a payment remittance?
When you receive payment for services the claim will pay per the member’s benefits with any amount over the reference cost being applied to the benefit maximum.

Is there anything different that I need to submit with member claims?
No. You should continue to submit your claims as you previously have to BlueCross BlueShield of Western New York.

Who do I contact if I have a question?
If you have any questions regarding the reference-based benefits, please contact BlueCross BlueShield of Western New York at 1-800-444-2012.

Coverage and Eligibility Verification
For BlueCross BlueShield of Western New York members:
Call 1-800-444-2012
Electronic: Log on to wnyhealthenet.org

For other Blue plans members, contact BlueCard Eligibility® by phone or log on to HEALTHeNET to verify the patient’s eligibility and coverage:
Call 1-800-676-BLUE (2583)
Electronic: Log on to wnyhealthenet.org

Submit a HIPAA 270 transaction (eligibility inquiry) to BlueCross BlueShield of Western New York.

You can receive real-time responses to your eligibility requests for out-of-area members between 6 a.m. and midnight, Eastern Time, Monday through Saturday.

Call BlueCard Eligibility 1-800-676-BLUE (2583)

1. English and Spanish speaking phone operators are available to assist you.

2. Blue Plans are located throughout the country and may operate on a different time schedule than BlueCross BlueShield of Western New York... You may be transferred to a voice response system linked to customer enrollment and benefits outside that Plan’s regular business hours.

3. The BlueCard. Eligibility line is for eligibility, benefit and precertification/referral authorization inquiries only. It should not be used for claim status. See Claim Filing section for claim filing information.

Electronic Health ID Cards
Some local BCBS Plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process.

- Electronic health ID cards enables electronic transfer of core subscriber/member data from the ID card to the provider’s system.
• A Blue electronic health ID card has a magnetic stripe on the back of the ID card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the three-track magnetic stripe.
• Core subscriber/member data elements embedded on the third track of the magnetic stripe include: subscriber/member name, subscriber/member ID, subscriber/member date of birth and Plan ID.
• The Plan ID data element identifies the health plan that issued the ID card. Plan ID will help providers facilitate health transactions among various payers in the marketplace.
• Providers will need a track 3 card reader in order for the data on track 3 of the magnetic stripe to be read (the majority of card readers in provider offices only read tracks 1 & 2 of the magnetic stripe; tracks 1 & 2 are proprietary to the financial industry).

Sample of electronic health ID card:

How to Obtain Utilization Review
You should remind patients that they are responsible for obtaining precertification/preauthorization for out-patient services from their Blue Plan. Participating providers are
responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract. In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

Providers must follow specified timeframes for pre-service review notifications:
- 48 hours to notify the member’s Plan of change in pre-service review
- 72 hours for emergency/urgent pre-service review notification.

General information on precertification/preauthorization information can be found on the Out-of-Area member Medical Policy and Preauthorization/Precertification Router at bcbswny.com/web/content/WNYprovider/bluecard/out-of-area-policy-search.html utilizing the prefix found on the member ID card.

You may contact the member’s plan by calling the number on the back of their card, or:
- Call BlueCard Eligibility 1.800.676.BLUE (2583)—ask to be transferred to the utilization review area.
- When precertification/preauthorization for a specific member is handled separately from eligibility verifications at the member’s Blue Plan, your call will be routed directly to the area that handles precertification/pre-authorization. You will choose from four options depending on the type of service for which you are calling:
  - Medical/Surgical
  - Behavioral Health
  - Diagnostic Imaging/Radiology
  - Durable/Home Medical Equipment (D/HME)

If you are inquiring about both, eligibility and precertification/preauthorization through 1-800-676-BLUE (2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the precertification/preauthorization area.

- Submit an electronic HIPAA 278 transaction (referral/authorization) to BlueCross BlueShield of Western New York
- The member’s Blue Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

When obtaining precertification/preauthorization, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to follow-up immediately with a member’s Blue Plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.
Electronic Provider Access
Electronic Provider Access gives providers the ability to access out-of-area member’s Blue Plan (Home Plan) provider website to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, precertification, preauthorization and prior approval, amongst other pre-claim processes. Electronic Provider Access (EPA) enables providers to use their local Blue Plan provider website to gain access to an out-of-area member’s Home Plan provider website, through a secure routing mechanism. Once in the Home Plan provider website, the out-of-area provider has the same access to electronic pre-service review capabilities as the Home Plan’s local providers.
The availability of EPA varies depending on the capabilities of each Home Plan. Some Home Plans have electronic pre-service review for many services, while others do not. The following describes how to use EPA and what to expect when attempting to contact Home Plans.

Using the EPA Tool
The first step for providers is to log on to bcbswny.com/provider and log in. Under Quick Links, you then select the menu option: Pre-Service Review for Out-of-Area Members (includes notification, precertification, preauthorization, and prior approval).

Next, enter the prefix from the member’s ID card. The prefix is the first three characters that precede the member id.

Note: You can first check whether precertification is required by the home plan by either:
1. Sending a service-specific request through Blue Exchange.
2. Accessing the Home Plan’s precertification requirements pages by using the medical policy router:
   bcbswny.com/web/content/WNYprovider/bluecard/out-of-area-policy-search.html

Entering the member’s prefix from the ID card automatically routes you to the Home Plan EPA landing page. This page welcomes you to the Home Plan website and indicates that you have left BlueCross BlueShield of Western New York website. The landing page allows you to connect to the available electronic pre-service review processes. The screens and functionality of Home Plan pre-service review processes vary widely, Home Plans may include instructional documents or e-learning tools on the Home Plan landing page to provide instruction on how to conduct an electronic pre-service review. The page also includes instructions for conducting pre-service review for services where the electronic function is not available.

The home plan landing page looks similar across home plans, but will be customized to the particular home plan based on the electronic pre-service review services they offer.
Provider Financial Responsibility for Pre-Service Review for BlueCard Members
BlueCross BlueShield of Western New York participating providers are responsible for obtaining pre-service review for inpatient facility services for BlueCard® members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers must also:

- Notify the member’s Blue Plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member’s Blue Plan for pre-service review or for a change or modification of the pre-service review, may cause the claim to deny for inpatient facility services. The BlueCard® member must be held harmless and cannot be balance-billed if pre-service review has not occurred.

Pre-service review contact information for a member’s Blue Plan is provided on the member’s identification card. Pre-service review requirements can also be determined by:

- Using the Electronic Provider Access (EPA) tool available at BlueCross BlueShield of Western New York provider website at bcbswny.com/provider. Note: the availability of EPA will vary depending on the capabilities of each member’s Blue Plan
- Submitting an ANSI 278 electronic transaction to BlueCross BlueShield of Western New York or calling 1.800.676.BLUE.

Services that deny as not medically necessary remain member liability.

Who do I contact if I have additional questions on provider financial responsibility from pre-service review?
If you have any questions on Provider Financial Responsibility or general questions, please call BlueCross BlueShield of Western New York at 1-800-444-2012.

*Unless the member signed a written consent to be billed prior to the rendering service.

Updating Your Provider Information
Maintaining accurate provider information is critically important to ensure the consumers have timely access to care. Updated information helps us maintain accurate provider directories and also ensures that providers are more easily accessible to members. Additionally, plans are required by Centers for Medicare and Medicaid Services (CMS) to include accurate information in provider directories for certain key provider data elements and accuracy of directories are routinely reviewed/audited by CMS.

Since it is the responsibility of each provider to inform Plans when there are changes, providers are reminded to notify BlueCross BlueShield of Western New York of any changes to their demographic information or other key pieces of information, such as
change in their ability to accept new patients, street address, phone number or any other change that affects patient access to care. For BlueCross BlueShield to remain compliant with federal and state requirements, changes must be communicated to us minimally 30 days prior to the change, or as soon as possible so that members have access to the most current information in the Provider Directory.

**Key Data Elements**
The data elements required by CMS and crucial for member access to care are as follows:

- Physician Name
- Location, e.g., address, suite city/state, zip code
- Phone Number
- Accepting new patient status
- Hospital affiliations
- Medical group affiliations

Plans are also encouraged (and in some cases required by certain regulatory/accrediting entities) to include accurate information for the following data elements:

- Physician gender
- Languages spoken
- Office hours
- Specialties
- Physical disabilities accommodations, e.g., wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, other accessible equipment
- Indian Health Service Status
- Licensing Information, i.e., medical license number, license state, national provider number
- Provider credentials, i.e., board certification, place of residency, internship, medical school, year of graduation
- Email and website address
- Hospital has an emergency department, if applicable

**How to update your information**
You should routinely check your current practice information by going to [www.bcbswny.com/content/WNYHome/toolsandresources/find-a-doctor.html](http://www.bcbswny.com/content/WNYHome/toolsandresources/find-a-doctor.html). If your information is not correct and updates are needed, please provide the correct information as soon as possible by completing a Provider Demographic Change Form at-[www.bcbswny.com/content/WNYprovider/tools-resources/forms.html](http://www.bcbswny.com/content/WNYprovider/tools-resources/forms.html).
Section 3 - Claim Filing

How Claims Flow through BlueCard

Below is an example of how claims flow through BlueCard

1. Member of another Blue Plan receives services from the provider.

2. Provider submits claim to the local Blue Plan.

3. Local Blue Plan recognizes BlueCard member and transmits standard claim format to the member’s Blue Plan.

4. Member’s Blue Plan adjudicates claim according to member’s benefit plan.

5. Member’s Blue Plan issues an EOB to the member.

6. Member’s Blue Plan transmits claim payment disposition to the local Blue Plan.

7. Local Blue Plan pays the provider.

After the member of another Blue Plan receives services from you, you should file the claim with BlueCross BlueShield of Western New York. We will work with the member’s Plan to process the claim and the member’s Plan will send an explanation of benefit or EOB to the member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the members benefits and coverage.

You should always submit claims to BlueCross BlueShield of Western New York.

Following these helpful tips will improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at wnyhealthenet.org or by calling 1.800.676.BLUE (2583). Be sure to provide the member’s prefix.
- Verify the member’s cost sharing amount before processing payment. Please do not process full payment upfront.
- Indicate any payment you collected from the patient on the claim. (On the 837 electronic claim submission form, check field AMT01=F5 patient paid amount; on the CMS1500 locator 29 amount paid; on UB92 locator 54 prior payment; on UB04 locator 53 prior payment.)
Submit all BlueCard® claims to BlueCross BlueShield of Western New York. Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character prefix. Submit claims with only valid prefix; claims with incorrect or missing prefixes and member identification numbers cannot be processed.

In cases where there is more than one payer and a Blue Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue claim. Upon receipt, BlueCross BlueShield will electronically route the claim to the member's Blue plan. The member's plan then processes the claim and approves payment.

BlueCross BlueShield will reimburse you for services.

- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claim automatically, actually slows down the claims payment process and creates confusion for the member.
- To check claim status, contact BlueCross BlueShield of Western New York at 1-800-444-2012 or submit an electronic HIPAA 276 transaction (claim status request) to wnyhealthenet.org.

**Medicare-Related Claims – Refer to bsbswny.com BlueCard Section**

**Medicare Advantage Claims**

Medicare Advantage® (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as “traditional Medicare.”

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), and private fee-for-service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage (by calling 1.800.BLUE (2583) or submitting an electronic inquiry) for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules, may vary depending on the Medicare Advantage plan.
Types of Advantage Plans

Medicare Advantage HMO
A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits and the coverage rules may vary by Medicare Advantage plan.

Medicare Advantage POS
A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine — at the point of service — whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO’s provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO’s provider network.

Medicare Advantage PPO
A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Blue Medicare Advantage PPO members have in-network access to Blue MA PPO providers.

Medicare Advantage PFFS
A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan’s terms and conditions of participation. Acceptance is “deemed” to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage Organization, rather than the Medicare program, pays for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instance where the provider is a network provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with BlueCross BlueShield of Western New York.
- If you do provide services, you will do so under the Terms and Conditions of that member’s Blue Plan.
- MA PFFS Terms and Conditions might vary for each Blue Plan and we advise that you review them before servicing MA PFFS members.
• Please refer to the back of the member's ID card for information on accessing the Plan’s Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.
• Submit your MA PFFS claims to BlueCross BlueShield of Western New York.

Medicare Advantage Medical Savings Account (MSA)
Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

Medicare Advantage PPO Network Sharing

What is BCBS Medicare Advantage PPO Network Sharing?
All Blue Cross Blue Shield Medicare Advantage PPO Plans participate in reciprocal network sharing. This network sharing allows all Blue Cross Blue Shield MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue Cross Blue Shield MA PPO Plan as long as the member sees a contracted MA PPO provider.

What does the BCBS Medicare Advantage (MA) PPO Network Sharing mean to me?
If you are a contracted MA PPO provider with BlueCross BlueShield of WNY and you see MA PPO members from other Blue Cross Blue Shield Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your BlueCross BlueShield of Western New York contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with BlueCross and BlueShield of WNY and you provide services for any Blue Cross Blue Shield Medicare Advantage members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member’s in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area member from one of these plans participating in the BlueCross BlueShield MA PPO network?
You can recognize a Medicare Advantage member when their BlueCross BlueShield member ID card has the following logo:

The “MA” in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard
Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Do I have to provide services to Medicare Advantage PPO members from other BlueCross BlueShield plans?
If you are a contracted Medicare Advantage PPO provider with BlueCross BlueShield of Western New York you must provide the same access to care as you do for out of area Blue Cross Blue Shield MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other Blue Cross Blue Shield Plans but you are not required to do so. Should you decide to provide services to Blue Cross Blue Shield Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member’s out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local BlueCross BlueShield Medicare Advantage PPO members?
If your practice is closed to new local Blue Cross Blue Shield MA PPO members, you do not have to provide care for Blue Cross Blue Shield MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

How do I verify benefits and eligibility?
Call BlueCard Eligibility Line at 1.800.676.BLUE (2583) and provide the member’s three-digit prefix located on the ID card.

You may also submit electronic eligibility requests for BlueCross BlueShield members:

- Log into wnyhealthenet.org
- Follow link to verify member eligibility
- Submit your request

Where do I submit the claim?
You should submit the claim to BlueCross BlueShield of Western New York under your current billing practices. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

What will I be paid for providing services to these out-of-area Medicare Advantage PPO network sharing members?
If you are a MA PPO contracted provider with BlueCross BlueShield, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. After you submit the MA claim, BlueCross BlueShield will work with the other plan to determine benefits and send you the payment.
What will I be paid for providing services to Medicare Advantage out-of-area members not participating in the Medicare Advantage PPO Network Sharing?
When you provide covered services to other Blue Cross Blue Shield Medicare Advantage out-of-area members' benefits will be based on the Medicare allowed amount. Once you submit the MA claim, BlueCross BlueShield of Western New York will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.

What is the member cost sharing level and co-payments?
A MA PPO member cost sharing level and co-payment is based on the member's health plan. You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 1.800.676.BLUE (2583).

May I balance bill the member the difference in my charge and the allowance?
No, you may not balance bill the member for this difference. Members may be billed for any deductibles, coinsurance, and/or copays.

What if I disagree with the reimbursement amount I received?
If there is a question concerning the reimbursement amount, contact your local plan at 1-800-444-2012.

Who do I contact if I have a question about MA PPO network sharing?
If you have any questions regarding the MA program or products, contact BlueCross BlueShield of WNY at: 1-800-444-2012.

What is BlueCross BlueShield Medicare Advantage PPO Network Sharing?
Network sharing allows MA PPO members from MA PPO Blue Cross Blue Shield Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted Medicare Advantage PPO provider. Medicare Advantage PPO shared networks are available in 35 states and one territory:

- Alabama
- Arkansas
- California
- Colorado
- Connecticut
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois*
- Indiana
- Kentucky
- Maine
- Massachusetts
- Michigan
- Missouri
- Montana
- North Carolina
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- South Carolina
- Tennessee
- Texas
- Utah
- Virginia
- Washington
- Wisconsin
- West Virginia

*participating
Reimbursement for Medicare Advantage PPO, HMO, POS, PFFS

Note to Provider: The reimbursement information below applies when a provider treats a Blue Cross Blue Shield Medicare Advantage member to whom the provider's contract does not apply.

Examples:
- A provider that is contracted for Medicare Advantage PPO business treats a Medicare Advantage HMO member.
- A provider that is contracted for commercial business only treats a MA PPO member.
- A provider that is contracted for Medicare Advantage HMO business treats any MA PPO member.
- A provider that is contracted for local Medicare Advantage HMO business treats an out-of-area MA HMO member.
- A provider that is not contracted with the local Plan treats a MA HMO member.

Based upon the Centers for Medicare and Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue Cross Blue Shield Plan, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Special payment rules apply to hospitals and certain other entities (e.g., skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Providers that are paid on a reasonable cost basis under Original Medicare should send their CMS Interim Payment Rate letter with their Medicare Advantage claim. This letter will be needed by the Plan to calculate the Medicare Allowed amount.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Cross Blue Shield Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

NOTE: Enrollee payment responsibilities can include more than copayments (e.g., deductibles). Please review the remittance notice concerning Medicare Advantage plan payment, member’s payment responsibility, and balance billing limitations.

Medicare Advantage Private-Fee-For-Service (PFFS) Claim Reimbursement
If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, but are not obligated to provide services to such member under a contract with
a Blue Cross Blue Shield Plan, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules by reviewing the Terms & Conditions under the member’s Blue Plan. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Cross Blue Shield Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

**NOTE TO PROVIDER:** The reimbursement information below applies when a provider treats a Blue Cross Blue Shield Medicare Advantage member to whom the provider’s contract applies.

Examples:

- A provider that is contracted for Medicare Advantage PPO business treats an out-of-area Medicare Advantage PPO member.
- A provider that is contracted for Medicare Advantage HMO business treats an MA HMO member from the local plan.

If you are a provider who accepts Medicare assignment and you render services to any Blue Cross Blue Shield Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue Cross Blue Shield Plan, you will be considered a contracted provider and be reimbursed per the contractual agreement.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Cross Blue Shield Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

**Health Insurance Marketplaces (AKA Exchanges)**

**Health Insurance Marketplace Overview**

The Patient Protection and Affordable Care Act of 2010 provides for the establishment of Health Insurance Marketplaces (i.e., Exchanges), in each state, where individuals and small businesses can purchase qualified insurance coverage through internet websites.

The intent of the Marketplace is to:

- Create a more organized and competitive health insurance marketplace by offering consumers a choice of health insurance plans,
- Establish common rules regarding insurance offerings and pricing,
- Provide information to help consumers better understand the options available to them and,
• Allow individual and small businesses to have the purchasing power comparable to that of large businesses

The Marketplaces makes it easier for consumers to compare health insurance plans by providing transparent information about health insurance plan provisions such as product information, premium costs, and covered benefits, as well as a plan’s performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.

All states have health insurance marketplaces where consumers can compare health insurance product features, coverage, and costs. Some states have set up their own, state-based Marketplace. In other states, the U.S. Department of Health and Human Services (HHS) has established a federally facilitated Marketplace, federally supported Marketplace, or a state-partnership Marketplace in the state. Blue plans that offer products on the Marketplaces collaborate with the state and federal governments for eligibility, enrollment, reconciliation, and other operations to ensure that consumers can seamlessly enroll in individual and small business health insurance products.

Exchange Individual Grace Period
The ACA mandates a three month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month’s premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. The ACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue Plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally mandated individual grace period, providers may receive a notification from BlueCross BlueShield indicating that the member is in the grace period.

Exchange Individual Grace Period – Post Service Notification Letter to Provider
Communication to providers will include the following information:
1. Notice-unique identification number (claim includes member information):
   Claim #: __________
2. Name of the QHP and affiliated issuer (Home Plan name)
3. Explanation of the three month grace period:

Under the Patient Protection and Affordable Care Act (PPACA), there is a three month grace period under Exchange-purchased individual insurance policies, when a premium due is not received for members eligible for premium subsidies. During this grace period, carriers may not dis-enroll members and, during the second and third months of the grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid.
4. Purpose of the notice, applicable dates of whether the enrollee is in the second or third month of the grace period & individuals affected under the policy and possibly under care of the provider:

Please be advised that a premium due has not been received for this subsidy eligible member and that the member and any eligible dependents are and at the time that your care was provided, were in the second or third month of the Exchange individual health insurance grace period. The above-referenced claim thus was pended due to non-payment of premium, and will be denied if the premium is not paid by the end of the grace period.

5. Consequences:
If the premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.

6. QHP customer service telephone number:
Please feel free to contact BlueCross BlueShield of Western New York Monday through Friday, at 1-800-444-2012 if you have any questions regarding this claim.

Health Insurance Marketplaces Claims

What else do I need to know?
The products offered on the Marketplaces will follow local business practices for processing and servicing claims. Providers should continue to follow current practices with BlueCross BlueShield of Western New York for claims processing and handling such as outlined below. (Note: Local Plan may consider including a link to their website or provider website for the below topics.)

- Eligibility and Benefits
- Care Management
  - Pre-Service Review
  - Medical Policy
- Claim Pricing and Processing
  - Contracting
  - Claim Filing
  - Pricing
  - Claim Processing
  - Medical Records
  - Payment
  - Customer Service
International Members

How do I identify international members?
Occasionally, you may see identification cards from members residing abroad or from foreign Blue Plan members. These ID cards will contain three character prefixes. Please treat these members the same as domestic Blue Plan members.

How do I submit claims for International Blue members?
The claim submission process for international BlueCross and BlueShield Plan members is the same as for domestic BlueCross and/or BlueShield Plan members. You should submit the claim directly to BlueCross BlueShield of Western New York.

Coding
Code claims as you would for BlueCross BlueShield of Western New York claims.

Ancillary Claims
Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies and Specialty Pharmacy providers. File claims for these providers as follows:

- Independent Clinical Laboratory (Lab)
  - The Plan in whose state the specimen was drawn based on the location of the referring provider.

- Durable/Home Medical Equipment and Supplies (D/HME)
  - The Plan in whose state the equipment was shipped to or purchased at a retail store.

- Specialty Pharmacy
  - The Plan in whose state the Ordering Physician is located.

Refer to bcbswny.com Ancillary Claims filing Mandate, BlueCard Section

Air Ambulance Claims

Claims for air ambulance services must be filed to the Blue Plan in whose service area the point of pickup ZIP code is located.

NOTE: If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

<table>
<thead>
<tr>
<th>Service Rendered</th>
<th>How to file (required fields)</th>
<th>Where to file</th>
<th>Example</th>
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<td>Air Ambulance Services</td>
<td>Point of pickup ZIP Code:</td>
<td>File the claim to the Plan in whose service area the point of pickup ZIP code is located.</td>
<td>• The point of pickup ZIP code is in Plan A service.</td>
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<tr>
<td>Service Rendered</td>
<td>How to file (required fields)</td>
<td>Where to file</td>
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<td>Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup</td>
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<td>point of pickup ZIP code is located*.</td>
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<td>− For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional.</td>
<td></td>
<td>*BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.</td>
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<td>• Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual.</td>
<td></td>
<td>• The claim must be filed to Plan A, based on the point of pickup ZIP code.</td>
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<td>− Form Locators (FL) 39-41</td>
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<td>− Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee.</td>
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<td>− Value: Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.</td>
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<td>− For electronic claims, populate the origin information (ZIP code of the point of pick-up) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional.</td>
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- The air ambulance claims filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.

- Where possible, providers are encouraged to verify Member Eligibility and Benefits by contacting the phone number on the back of the Member ID card or calling 1-800-676-BLUE.

- Providers are encouraged to utilize in-network participating air ambulance providers to reduce the possibly of additional member liability for covered benefits.
• Members are financially liable for air ambulance services not covered under their benefit plan. It is the provider’s responsibility to request payment directly from the member for non-covered services.

• Providers who wish to establish Trading Partner Agreements with other Plans should reference bcbswny.com website to obtain additional contact information.

• If you have any questions about where to file your claim, please contact BlueCross BlueShield of Western New York BlueCard Service Line @ 1-800-444-2012

Contiguous Counties/Overlapping Service Area

Contiguous Counties
Claims filing rules for contiguous area providers are based on the permitted terms of the provider contract, which may include:

• Provider Location (i.e., Plan service area is the provider’s office located)
• Provider contract with the two contiguous counties (i.e., is the provider contracted with only one or both service areas).
• The member’s Home plan and where the member works and resides (i.e. is the member’s Home Plan with one of the contiguous counties plans).
• The location of where the services were received (i.e. does the member work and reside in one contiguous county and see a provider in another contiguous county).

Overlapping Service Areas

Submission of claims in Overlapping Service Areas is dependent on what Plan(s) the Provider contracts with in that state, the type of contract the Provider has (ex. PPO, Traditional) and the type of contract the member has with their Home Plan.

• If you contract with all local Blue Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area Blue Plan member’s claim with either Plan.
• If you have a PPO contract with one Blue Plan, but a Traditional contract with another Blue Plan, file the out-of-area Blue Plan member’s claim by product type.
• For example, if it’s a PPO member, file the claim with the Plan that has your PPO contract.
• If you contract with one Plan but not the other, file all out-of-area claims with your contracted Plan.

Medical Records

Blue Plans have made many improvements to the medical records process to make it more efficient and are able to send and receive medical records electronically with other Blue Plans. This method significantly reduces the time it takes to transmit supporting
documentation for our out of area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

Under what circumstances may the provider get requests for medical records for out-of-area members?

1. As part of the preauthorization process — If you receive requests for medical records from other Blue Plans prior to rendering services, as part of the pre-authorization process, you will be instructed to submit the records directly to the member’s Plan that requested them. This is the only circumstance where you would not submit them to BlueCross BlueShield of Western New York.
2. As part of claim review and adjudication — These requests will come from BlueCross BlueShield of Western New York in the form of a letter, fax, email, or electronic communication requesting specific medical records and including instructions for submission

BlueCard Medical Record Process for Claim Review

1. An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.
2. A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact BlueCross BlueShield of Western New York BlueCard Service 1-800-444-2012 to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.
3. If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact BlueCross BlueShield of Western New York to determine if the records are needed from your office.
4. Upon receipt of the information, the claim will be reviewed to determine the benefits.

Helpful Ways You Can Assist in Timely Processing of Medical Records

1. If the records are requested following submission of the claim, forward all requested medical records to BlueCross BlueShield of Western New York.
2. Follow the submission instructions given on the request, using the specified physical or email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
3. Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by BlueCross Blue Shield of Western New York.
4. Please submit the information to BlueCross BlueShield of Western New York as soon as possible to avoid further delay.
5. Only send the information specifically requested. Frequently, complete medical records are not necessary.
6. Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

Please mail to:
BlueCard Dept.
BlueCross BlueShield of Western New York
PO Box 80
Buffalo, NY 14240

Adjustments
Contact BlueCross BlueShield of Western New York if an adjustment is required. We will work with the member’s Blue Plan for adjustments; however, your workflow should not be different.

Appeals
You must submit a provider claims appeal form located on the Provider website.

Appeals for all claims are handled through BlueCross BlueShield of Western New York. We will coordinate the appeal process with the member’s Blue Plan, if needed.

Coordination of Benefits (COB) Claims
Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member’s contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

- BlueCross BlueShield of Western New York or any other Blue Plan is the primary payer, submit other carrier’s name and address with the claim to BlueCross BlueShield of Western New York. If you do not include the COB information with the claim, the member’s Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.

- Other non-Blue health plan is primary and BlueCross BlueShield of WNY or any other Blue Plan is secondary, submit the claim to BlueCross BlueShield of Western New York only after receiving payment from the primary payer, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member’s Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.

Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the BlueCross BlueShield of Western New York remittance advice as “patient liability” might be different from the actual amount the patient owes you, due to the...
combination of the primary insurer payment and your negotiated amount with BlueCross BlueShield of Western New York.

For Professional claims if the member does not have other insurance, it is imperative on the electronic HIPAA 837 claims submission transaction or CMS 1500 claim form, in box 11D, either “YES” or “NO” be checked. Leaving the box unmarked can cause the member’s Plan to stop the claim to investigate for COB.

Coordination of Benefits Questionnaire
To streamline our claims processing and reduce the number of denials related to Coordination of Benefits, a Coordination of Benefits (COB) questionnaire is available to you at bcbswny.com/tools/references/forms that will help you and your patients avoid potential claim issues.

When you see any Blue members and you are aware that they might have other health insurance coverage give a copy of the questionnaire to them during their visit. Providers should ensure that the form is completely filled out and at a minimum, includes your name and tax identification or NPI number, the policy holder’s name, group number and identification number including the three character prefix and the member’s signature. Once the form is complete, send it to your local Blue Plan as soon as possible. Your local Blue Plan will work with the member’s Plan to get the COB information updated. Collecting COB information from members before you file their claim eliminates the need to gather this information later, thereby reducing processing and payment delays.

Claim Payment
If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This also causes member confusion because of multiple Explanations of Benefits (EOBs). BlueCross BlueShield of Western New York’s standard time for claims processing is 30 days, however claim processing times at various BlueCross and/or BlueShield Plans vary. If you do not receive your payment or a response regarding your payment, please call BlueCross BlueShield of Western New York at 1-800-444-2012 or visit our online transaction site to check the status of your claim at wnyhealthenet.org.

In some cases, a member’s Blue Plan may suspend a claim because medical review or additional information is necessary. When resolution of claim suspensions requires additional information from you, BlueCross BlueShield of Western New York may either ask you for the information or give the member’s Plan permission to contact you directly.

Claim Status Inquiry
BlueCross BlueShield of Western New York is your single point of contact for all claim inquiries. Claim status inquiries can be done by:

Phone: 1-800-444-2012
Electronically: Log on to wnyhealthenet.org
Calls from Members and Others with Claim Questions

If members contact you, advise them to contact their Blue Plan and refer them to their ID card for a customer service phone number.

The member’s Plan should not contact you directly, but if the member's Plan contacts you and asks you to submit the claim to them, refer them to BlueCross BlueShield of Western New York.

Value Based Provider Arrangements
Plans have value-based care delivery arrangements in place with their providers. Each Plan has created their own arrangement with their provider(s), including reimbursement arrangements. Due to the unique nature of each plan/provider arrangement, there is no common provider education template for value-based care delivery arrangements that can be created and distributed for use by all plans.

Key Contacts

Where to Find More Information
For more information, call BlueCross BlueShield of Western New York at 1-800-444-2012 or visit the BlueCross BlueShield of Western New York website at bcbswny.com.
Section 4 - Frequently Asked Questions

BlueCard Basics

1. What Is the BlueCard® Program?
BlueCard is a national program that enables members of one Blue Plan to obtain health care services while traveling or living in another BlueCross and BlueShield Plan’s service area. The program links participating health care providers with the independent BlueCross and BlueShield Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program allows you to conveniently submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan. Your local Blue Plan is your sole contact for claims payment, problem resolution and adjustments.

2. What products and accounts are excluded from the BlueCard Program?
Stand-alone dental and prescription drugs are excluded from the BlueCard Program. In addition, claims for the Federal Employee Program (FEP) are exempt from the BlueCard Program. Please follow your FEP billing guidelines.

3. What is the BlueCard Traditional Program?
A national program that offers members traveling or living outside of their Blue Plan's area traditional or indemnity level of benefits when they obtain services from a physician or hospital outside of their Blue Plan's service area.

4. What is the BlueCard PPO Program?
A national program that offers members traveling or living outside of their Blue Plan’s area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

5. What is the BlueCard Managed Care/POS Program?
The BlueCard Managed Care/POS program is for members who reside outside their Blue Plan’s service area. Unlike in the BlueCard PPO program, in the BlueCard Managed Care/POS, members are enrolled in BlueCross BlueShield of Western New York’s network and have a primary care physician (PCP). You can recognize BlueCard Managed Care/POS members who are enrolled in the BlueCross BlueShield of Western New York network through the member ID card as you do for all other BlueCard members.

6. Are HMO patients serviced through the BlueCard® Program?
Yes, occasionally, Blue HMO members affiliated with other Blue Plans will seek care at your office or facility. You should handle claims for these members the same way you do for BlueCross BlueShield of Western New York members and Blue traditional, PPO, and POS patients from other Blue Plans by submitting them to BlueCross BlueShield of Western New York.
Identifying Members and ID Cards

1. How do I identify members?
When members from other BlueCross and/or BlueShield Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifier for out of area members is the prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo
- No suitcase

2. What is a "prefix?"
The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the BlueCross and/or BlueShield Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage.

3. What do I do if a member has an identification card without a prefix?
Some members may carry outdated identification cards that may not have a prefix. Please request a current card from the member.

4. How do I identify BlueCard Managed Care/POS member
The BlueCard Managed Care program is for members who reside outside their Blue Plan's service area. However, unlike other BlueCard Programs, BlueCard Managed Care/POS members are enrolled in BlueCross BlueShield of Western New York’s network and primary care physician (PCP) panels. You can recognize BlueCard Managed Care/POS members who are enrolled in BlueCross BlueShield of Western New York network through the member ID card as you do for all other BlueCard members.

5. How do I identify Medicare Advantage members?
Members will not have a standard Medicare card; instead, a Blue logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

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<th>Member ID cards for Medicare Advantage products will display one of the benefit</th>
<th>Health Maintenance Organization</th>
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<tbody>
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<td><strong>MEDICARE ADVANTAGE HMO</strong></td>
<td>Health Maintenance Organization</td>
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<tr>
<td><strong>MEDICARE ADVANTAGE MSA</strong></td>
<td>Medical Savings Account</td>
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<tr>
<td><strong>MEDICARE ADVANTAGE PFFS</strong></td>
<td>Private Fee-For-Service</td>
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</table>
When these logos are displayed on the front of a member’s ID card, it indicates the coverage type the member has in his/her Blue Plan service area or region. However, when the member receives services outside his/her Blue Plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network-sharing arrangements.

BlueCross BlueShield of Western New York participates in Medicare Advantage PPO Network Sharing arrangements, and contracted provider reimbursement is based on the contracted rate with BlueCross BlueShield of Western New York. Non-contracted provider reimbursement is the Medicare allowed amount based on where services are rendered.

Tip: While all MA PPO members have suitcases on their ID cards, some have limited benefits outside of their primary carrier’s service area. Providers should refer to the back of the member’s ID card for language indicating that such restrictions apply.

6. How do I identify international members?
Occasionally, you may see identification cards from foreign BlueCross and/or BlueShield Plan members. These ID cards will also contain three-character prefixes. Please treat these members the same as domestic BlueCross and/or BlueShield Plan members.

7. What do I do if a member doesn’t have an ID card?
The member would need to be asked whom their plan coverage is with along with the three character prefix and their identification number. Once you have the member information, you would call 1-800-810-BLUE to obtain eligibility and benefits for the member.

Verifying Eligibility and Coverage

1. How do I verify membership and coverage?
For BlueCross BlueShield of Western New York members, contact our Customer Services Department at 1-800-544-2583. Providers can also log on to wnyhealthenet.org to verify member eligibility.

For other Blue Plans members, contact BlueCard Eligibility® by phone or BlueCross BlueShield of Western New York electronically at wnyhealthenet.org to verify the patient’s eligibility and coverage:
Phone: 1-800-676-BLUE (2583)
Electronic: wnyhealthenet.org
Utilization Review

1. How do I obtain utilization review?
You should remind patients that they are responsible for obtaining precertification/authorization for their services from their Blue plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility) you may also contact the member's Plan on the member's behalf. You can do so by:

For BlueCross BlueShield of Western New York members, contact our Utilization Management department at 1-800-677-3086 or (716) 884-2942.

For other Blue plans members:

- Phone - Call the utilization management/precertification number on the back of the member’s card
- If the utilization management number is not listed on the back of the member card – call 1-800-676-BLUE (2583) and ask to be transferred to the utilization review area
- Electronic: Submit a HIPAA 278 transaction (referral/authorization) to wnyhealthenet.com

Claims

1. Where and how do I submit claims?
You should always submit claims electronically to BlueCross BlueShield of Western New York. Be sure to include the member’s complete identification number when you submit the claim. The complete identification number includes the three character prefix —do not make up prefixes. Claims with incorrect or missing prefixes and member identification numbers cannot be processed.

2. How do I submit international claims?
The claim submission process for international BlueCross and/or BlueShield Plan members is the same as for domestic BlueCross and/or BlueShield Plan members. You should submit the claim directly to BlueCross BlueShield of Western New York.

3. How do I handle COB claims?
If after calling 1-800-676-BLUE or through other means you discover the member has a COB provision in their benefit plan and BlueCross BlueShield of Western New York is the primary payer, submit the claim with information regarding COB to:

BlueCross BlueShield of Western New York
PO Box 80
Buffalo, New York 14240-0080
If you do not include the COB information with the claim, the member’s Blue Plan or the insurance carrier will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

4. How do I handle Medicare Advantage Claims?
Submit claims to BlueCross BlueShield of Western New York. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by BlueCross BlueShield of Western New York.

5. How do I handle traditional Medicare-related claims?
When Medicare is the primary payer, submit claims to your local Medicare intermediary. All Blue claims are set up to automatically cross over (or forward) to the member’s Blue Plan after being adjudicated by the Medicare intermediary.

6. How do I submit Medicare Primary/Blue Plan Secondary claims?
For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.

When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member’s ID card for additional verification.

Be certain to include the prefix as part of the member identification number. The member’s ID will include the prefix in the first three positions. The prefix is critical for confirming membership and coverage, and key to facilitation prompt payments.

**When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan.**

If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in the process. **DO NOT** resubmit that claim to BlueCross BlueShield of Western New York. Duplicate claims will result in processing and payment delays.

If the remittance advice indicates that the claim was not crossed over, submit the claim to BlueCross BlueShield of Western New York, with the Medicare remittance advice.

In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.

For claim status inquiries, contact BlueCross BlueShield of Western New York at 1-800-444-2012.
7. When will I get paid for BlueCard® claims?
BlueCross BlueShield of Western New York’s Guidelines for Claims Payment BlueCard payments go out the same as any other payment to the provider. They will receive their remittance with the BlueCard claim number and the member prefix and ID number.

If you haven’t received payment, do not resubmit the claim. If you do, BlueCross BlueShield of Western New York will have to deny the claim as a duplicate. You will also confuse the member because he or she will receive another EOB and will need to call customer service. Please understand that timing for claims processing varies at each BlueCross BlueShield Plan.

The next time you don’t receive your payment or a response regarding your payment, please call BlueCross BlueShield of Western New York at 1-800-444-2012. In some cases, a member's BlueCross and BlueShield Plan may suspend a claim because medical review or additional information is necessary. When resolution of claim suspensions requires additional information from you, BlueCross BlueShield of Western New York will ask you for the information.

Contacts

1. Who do I contact with claims questions?
BlueCross BlueShield of Western New York
1-800-444-2012

2. How do I handle calls from members and others with claims questions?
If members contact you, tell them to contact their BlueCross and/or BlueShield Plan. Refer them to the front or back of their ID card for a customer service number. A member's Plan should not contact you directly, unless you filed a paper claim directly with that Plan. If the member's Plan contacts you to send them another copy of the member's claim, refer the Plan to BlueCross BlueShield of Western New York.

3. Where can I find more information?
For more information call BlueCross BlueShield of Western New York at 1-800-444-2012 or visit BlueCross BlueShield of Western New York at bcbswny.com.
Section 5 - Glossary of BlueCard Program Terms

Administrative Services Only (ASO)
ASO accounts are self-funded, where the local plan administers claims on behalf of the account, but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits or timely filing limitations.

BlueCross BlueShield of Western New York receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.

Affordable Care Act
The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

Prefix
Three characters preceding the subscriber identification number on BlueCross and/or BlueShield Plan ID cards. The prefix identifies the member’s BlueCross and/or BlueShield Plan or national account ad is required for routing claims.

bcbs.com
The BlueCross BlueShield Association’s website, which contains useful information for providers.

BlueCard Access® 1-800-810-BLUE (2583)
A toll-free 800 number for providers and members to use to locate health care providers in another BlueCross and/or BlueShield Plan’s area. This number is useful when you need to refer the patient to a physician or health care facility in another location.

BlueCard Doctor and Hospital Finder Website
www.bcbs.com/healthtravel/finder.html
A Web site you can use to locate healthcare providers in another Blue Plan’s area http://www.bcbs.com/healthtravel/finder.html. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you, as a provider, is incorrect on the Web site, please complete a Provider Demographic Change Form at - bcbswny.com/content/WNYprovider/tools-resources/forms.html
BlueCard Eligibility® 1-800-676-BLUE
A toll-free 800 number for you to verify membership and coverage information, and obtain precertification on patients from other BlueCross and/or BlueShield Plans.

BlueCard PPO
A national program that offers members traveling or living outside of their BlueCross and/or BlueShield Plan’s area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard PPO Member
Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of BlueCard PPO.

BlueCard Worldwide®
A medical assistance program that provides Blue members traveling or living outside the United States, Puerto Rico and U. S. Virgin Islands with access to doctors and hospitals around the world.

Coinsurance
A provision in a member’s coverage that limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional costs out-of-pocket.

Coordination of Benefits (COB)
Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member’s contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Copayment
A specified charge that a member incurs for a specified service at the time the service is rendered.

Deductible
A flat amount the member incurs before the insurer will make any benefit payments.

EPO
An Exclusive Provider Organization or EPO is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.
Essential Community Providers
Healthcare providers that serve predominately low-income, high-risk, special needs and medically-underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.

FEP
The Federal Employee Program.

Hold Harmless
An agreement with a health care provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the health care provider has contractually agreed on with a BlueCross and/or BlueShield Plan as full payment for these services.

Medicare Crossover
The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payer with Medicare’s supplemental insurance company.

Marketplace/Exchange
For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards. The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a Federally-facilitated Marketplace in any state that does not do so, or will not have an operable Marketplace for the 2014 coverage year, as determined in 2013.

Medicaid
A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women, Medicaid is governed by overall Federal guidelines in terms of eligibility, procedures, payment level, etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

Medicare Advantage
“Medicare Advantage” (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as “traditional Medicare.”
MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

**Medicare Supplemental (Medigap)**
Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the “gaps” in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn’t cover. Medigap policies are regulated under federal and state laws and are “standardized.” There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell. Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member’s Home Plan via Medicare Crossover process. Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.

**National Account**
An employer group with employee and/or retiree locations in more than one Blue Plan’s Service Area.

**Other Party Liability (OPL)**
A cost containment program that recovers money where primary responsibility does not exist because of another group health plan or contractual exclusions. Includes coordination of benefits, workers compensation, subrogation, and no-fault auto insurance.

**Plan**
Refers to any BlueCross and/or BlueShield plan.

**POS**
Point of Service or POS is a health benefit program in which the highest level of benefits is received when the member obtains services from his/her primary care provider/group and/or complies with referral authorization requirements for care. Benefits are still provided when the member obtains care from any eligible provider without referral authorization, according to the terms of the contract.

**PPO**
Preferred Provider Organization or PPO is a health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.
PPOB
A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.

Qualified Health Plan (QHP)
Under the Affordable Care Act, which started in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Small Business Health Options Program (SHOP)
Program designed to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The program allows employers to choose the level of coverage and offer choices among health insurance plans. SHOP insurance is generally available to employers with 1-50 employees, but in some states SHOP is available to employers with 1-100 employees.

State Children’s Health Insurance Program (SCHIP)
SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

Traditional Coverage
Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.
Section 6 - BlueCard® Program Quick Tips

The BlueCard Program provides a valuable service that lets you file all claims for members from other BlueCross BlueShield Plans to your local Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character prefix that precedes the member's ID number on the ID card.
- Call BlueCard Eligibility at 1-800-676-BLUE to verify the patient's membership and coverage or submit an electronic HIPAA 270 transaction (eligibility) to the local Plan.
- Submit the claim electronically to BlueCross BlueShield of Western New York. Always include the patient's complete identification number, which includes the three-character prefix.
- For claims inquiries, call BlueCross BlueShield of Western New York at 1-800-444-2012.