

2014 Participating Provider



Administrative Manual



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INTRODUCTION

Welcome to Blue Cross & Blue Shield of Rhode Island (BCBSRI).

We created this manual for physicians/providers, their office/billing staff members, and other healthcare professionals in the BCBSRI network. You will find a broad range of topics in this manual, such as key contacts and an overview of the various types of BCBSRI plans. In addition to this manual, our website, BCBSRI.com, offers access to even more resources for physicians and providers. We hope you find these tools to be valuable sources of information as you provide important services to our members.

The intent of this manual is to help facilitate your interactions with our company. We believe that our physician/provider community is vital to achieving our corporate vision: To improve the quality of life of our customers and of the people of Rhode Island by improving their health.

About BCBSRI

BCBSRI has been the state's leading health plan since 1939, now covering more than 600,000 members. BCBSRI is an independent licensee of the Blue Cross and Blue Shield Association.

Our Mission

Our mission is to improve members' health and peace of mind by facilitating their access to affordable, high-quality healthcare.

Toward that end we shall:

- Make high-quality health insurance available to a comprehensive range of consumers, including business owners, employees, self-paying, and unemployed individuals.
- Assist and support healthcare initiatives for individuals without healthcare insurance.
- Contribute to the improvement of medical and prevention services delivered in Rhode Island.
- Promote a coherent, integrated, and efficient statewide healthcare system that meets the needs of all Rhode Island residents.
- Ensure that BCBSRI is financially viable and will maintain the resources and stability necessary to accomplish our mission.

Simply stated, we hope to provide our members with a wide range of coverage options while empowering them to make more informed choices regarding their health.

The BCBSRI Family of Products

- BlueCHiP
- BlueCHiP for Healthy Options
- BlueCHiP for Medicare (individual and retiree group plans)
- Blue Cross Dental
- Blue MedicareRx, a regional prescription drug plan (PDP) available to Original Medicare beneficiaries and members in Medigap plans, such as Plan 65. Offered by the New England Joint Enterprise, Blue MedicareRx is a collaboration of BCBSRI, Blue Cross Blue Shield of Massachusetts, Blue Cross and Blue Shield of Vermont, and Anthem Blue Cross and Blue Shield of Connecticut.
- BlueSolutions for HSA
- BlueSolutions SelectRI
- BlueSolutions for HSA Direct
- BasicBlue Direct
- Classic Blue
- Dental Direct
- Federal Employees Plan (FEP)
- HealthMate Coast-to-Coast
- LifeStyleBlue
- Plan 65 (individual and retiree group plans)
- VantageBlue
- VantageBlue Direct
- VantageBlue Select
- VantageBlue SelectRI
- VantageBlue SelectRI Direct
- The New England Health Plans (NEHP)
 - HMO Blue New England
 - Blue Choice New England

Contacting BCBSRI

Please review this manual thoroughly. If you have questions, please call us at the appropriate phone number listed in Chapter 2 of this manual.

CHAPTER 2

KEY CONTACTS AND RESOURCES

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KEY CONTACTS AND RESOURCES

Key Contacts for Physicians/Providers

BCBSRI is committed to maintaining open lines of communication with all of our participating physicians/providers. We will direct all inquiries to the most appropriate resource as quickly and efficiently as possible to avoid disruption of your business activities.

There are three primary contact resources available for all physicians/providers and their office staff: BCBSRI.com, the Physician and Provider Service Center, and BlueLine. Directly contacting the appropriate resource will save you time and will enable us to respond more quickly.

For specific inquiries, you or your staff members can contact one of the following resources directly for:

- Routine member eligibility, benefit information, and claims status inquiries: BCBSRI.com or BlueLine
- Complaints and grievances: Physician and Provider Service Center
- Complex claims issues: Physician and Provider Service Center
- Referral questions: Physician and Provider Service Center
- Authorization information: BCBSRI.com or Physician and Provider Service Center
- Web access information: Physician and Provider Service Center
- Policies and procedures: BCBSRI.com or Physician and Provider Service Center

As a participating provider, you also have access to an external Provider Relations Representative who is assigned to your office. This representative acts as a central conduit of information between you and BCBSRI. Your representative is responsible for ensuring that you have all the information you need to function successfully as a participating physician/provider. He or she can also personally facilitate problem resolution on your behalf. Any questions can be directed to your representative, including inquiries regarding:

- Physician/provider education and responsibilities
- Office operations, assistance, and training
- Policies and procedures

Key Contact List for Physicians/Providers

BlueLine

(401) 272-1590 or 1-800-327-6712

Routine membership, eligibility, benefit information, and claims status for all BCBSRI members

Hours: 24 hours a day, seven days a week

Out-of-State Plans

1-800-676-BLUE (2583)

Membership and eligibility information for your Blue Cross and Blue Shield BlueCard members

Hours: 24 hours a day, seven days a week

Physician and Provider Service Center

(401) 274-4848 or 1-800-230-9050

Fax: (401) 459-2287

Complex claims inquiries, policies and procedures, business practice change requests, and Web access information

Hours: Monday through Friday, 8:00 a.m. to 4:30 p.m.

Provider Relations

(401) 274-4848 or 1-800-230-9050

Fax: (401) 459-5531

Physician/provider education responsibilities and policies and procedures

Hours: Monday through Friday, 8:00 a.m. to 4:30 p.m.

Credentialing Department

(401) 274-4848 or 1-800-230-9050

Fax: (401) 459-1369

Status of a credentialing and recredentialing application

Hours: Monday through Friday, 8:00 a.m. to 4:30 p.m.

Blue Cross Dental

(401) 453-4700 or 1-800-831-2400

Fax: (401) 459-2287

Patient membership and eligibility, enrollment applications, dentists/staff education and responsibilities, changes in provider status, policies and procedures, and claims inquiries

Hours: Monday through Friday, 8:00 a.m. to 4:30 p.m.

Facility Call Center

(401) 274-3103 or 1-800-637-3718, ext. 6067

Fax: (401) 459-2287

Hospital and facility claims inquiries, policies and procedures, and Web access information

Hours: Monday through Friday, 8:00 a.m. to 4:30 p.m.

Electronic Data Interchange (EDI) Outreach & Support Team

(401) 751-1673 or 1-800-343-5743

Email: hipaa.edi.support@bcbsri.org

Use the email for information about HIPAA transactions and code sets testing, etc. or contact the IT Service Desk

Hours: 24 hours a day, seven days a week

Information Technology (IT) Service Desk

(401) 751-1673 or 1-800-343-5743

Production problems with HIPAA transactions, issues with electronic claims transmissions, or difficulty retrieving Provider Control Reports

Hours: 24 hours a day, seven days a week

Utilization Management

(401) 272-5670 or 1-800-635-2477

Fax: (401) 272-8885

Inpatient admissions, emergency admission notification, skilled nursing facility admissions, cosmetic surgery reviews, out-of-state inpatient services, out-of-network services, speech therapy, outpatient pulmonary rehabilitation, experimental/investigational reviews, and other reviews necessary according to medical policy, such as gastric bypass surgery, genetic testing, preauthorization for some durable medical equipment, acute inpatient rehabilitation, private duty nursing, or any utilization management issue.

Hours: Monday through Friday, 8:00 a.m. to 4:30 p.m.

Case Management

(401) 459-2273 or 1-800-637-3718, ext. 2273

Fax: (401) 459-5804

To refer members with complex health conditions for health education, coordination of care, supportive resources, and assistance in self managing health conditions.

Hours: Monday through Friday, 8:00 a.m. to 4:30 p.m.

Key Contacts for BCBSRI Members

BCBSRI is equally committed to open communication with our members. By visiting BCBSRI.com or calling our Customer Service Department, members can get information regarding their membership, including inquiries on issues such as:

- Benefits and claims
- Eligibility and enrollment
- Choosing a primary care physician
- Member assistance and outreach programs
- Complaints and appeals
- Disease management and preventive health programs
- Member rights and responsibilities
- Special member services, such as our AT&T Language Line for members who do not speak English (*Customer Service Department only*)

Members should visit BCBSRI.com or call the number on their member identification card (our Customer Service number) whenever they have a question about their care or coverage.

Key Contact List for Members

Customer Service Department Hours for Numbers Below:

Customer Service hours for BlueCHiP for Medicare members are: October 1, 2014 to February 14, 2015: seven days a week, 8:00 a.m. to 8:00 p.m., and February 15, 2015 until the following annual enrollment period: Monday through Friday, 8:00 a.m. to 8:00 p.m. An automated answering system is available outside of these hours. Customer Service hours for all other plans are Monday through Friday, 8:00 a.m. to 8:00 p.m.

BlueCHiP for Medicare

(401) 277-2958 or 1-800-267-0439

All Other BCBSRI plans

(401) 459-5000 or 1-800-639-2227

Amica Medical Plan

1-877-302-6422

Gilbane

1-877-277-4455

Federal Employee Program (FEP)

1-800-377-4418

TDD for the Hearing Impaired

711

Blue Cross Dental (Hours: Monday through Friday, 8:00 a.m. to 4:30 p.m.)

(401) 453-4700 or 1-800-831-2400

If You Need Interpreter Services

We have Spanish-speaking customer service representatives, and we have access to interpreter service lines in numerous languages. This includes languages originating from Africa, Asia, Europe, the Middle East, South America, the Caribbean, and the Pacific Islands. We can also assist your provider in obtaining in-office sign language services. For more information on these services, please give us a call at the appropriate number above.

BCBSRI Organizational Structure and Committees

The corporate structure of BCBSRI is designed to help us work most effectively with you in meeting the following objectives:

- Maintain a geographically and culturally acceptable physician/provider network.
- Ensure that all physicians/providers meet our qualification standards.
- Monitor network performance against measurable standards.
- Identify areas of needed improvement at corporate, network, and individual levels.

Professional committees play an important part in our effort to facilitate close working relationships with BCBSRI physicians/providers and are closely involved with the day-to-day operation of BCBSRI's clinical programs.

Support Committees

The BCBSRI Board of Directors (BOD) has designated the Executive Quality Council (EQC) to be responsible for the oversight of all professional programs and activities. The EQC is supported by a number of subcommittees established as formal avenues of two-way communication. These committees are comprised of internal representatives from BCBSRI functional departments and external representatives from the provider network. You can find details about the EQC and its subcommittees in Chapter 8.

A listing of other committees is included below. For more information on committee activities, please contact your Provider Relations Representative.

Specialty Pharmacy and Therapeutics (SP&T) Committee

Purpose and Objectives

The SP&T Committee oversees the designation of drugs as being consistent with inclusion in the specialty drug program and the creation of specialty medication usage policies. SP&T promotes clinically appropriate safe and effective pharmacotherapy for the corporation on plan members. SP&T's chief responsibility is the establishment of a specialty drug list (except Medicare Advantage Part D). Actions of the SP&T are sent to the P & T Committee for ratification, but may be implemented upon SP&T approval as needed.

Responsibilities

The committee's responsibilities include, but are not limited to:

- Serve in an evaluative, educational and advisory capacity to BCBSRI.
- Develop, maintain, and promote a specialty formulary system based on appropriate rationale and cost-effective care, including the approval of prior authorization, step, and quantity limit program rules.
- Establish programs and procedures that promote safe, effective, and affordable specialty drug therapy for patients, including the review of utilization review criteria and quantity limits.

- Review the results of Drug Usage Evaluation (DUE)/Drug Utilization Review (DUR) and make recommendations to promote appropriate drug use.
- Recommend and/or assist in the formulation of educational programs to provide complete and/or current knowledge on matters related to specialty pharmaceuticals and drug use.
- Review and approve practice guidelines, as needed for efficacious pharmacotherapy.
- Monitor appropriateness of usage of specialty pharmacologic agents (under/overutilization and coordination of care).
- Work with the specialty pharmacies to promote clinical programs so as to improve efficacy and efficiency.

Network Management Advisory Committee

Purpose and Objectives

- Enhance and provide an opportunity for proactive communication.
- Serve as a forum for presenting new or changing policies and procedures.
- Provide information regarding BCBSRI initiatives.
- Exchange ideas for enhancing BCBSRI (e.g., BCBSRI.com, EDI transactions, and the BCBSRI IVR).
- Improve communication between BCBSRI and the provider community.

Committee Composition

Non-clinical office staff who have administrative and operational responsibilities with our network physicians

Responsibilities

- Serve as a liaison between the Network Management Advisory Committee and members of the network community.
- Review materials and provide professional evaluation of contents and make recommendations.

Healthcare Community Exchange Council

Committee Composition

- Senior Vice President and Chief Medical Officer
- Standing BCBSRI Representatives, including Network Management and Provider Relations
- Community physicians of various specialties

Medicare & Regulatory Compliance Committee

Committee Composition

- President and Chief Executive Officer
- Executive Vice President and Chief Operating Officer

- Executive Vice President and General Counsel and Chief Administrative Officer
- Senior Vice President and Chief Marketing Officer
- Senior Vice President and Chief Medical Officer
- Chief Financial Officer
- Vice President, Human Resources

Communication Channels

The world of healthcare is changing every day. We provide you with a variety of communication vehicles to help you stay informed of general managed care principles, regulatory requirements, proposed and enacted legislation that affects physicians and providers, and programs that are created in response to these issues. Our primary physician/provider communication vehicles include newsletters, BCBSRI.com, provider/office orientations, regional informational seminars, and webinars.

Provider Update

We produce a newsletter for physicians/providers: *Provider Update*. This monthly publication is posted to the Provider section of BCBSRI.com each month. These newsletters contain timely information on a number of topics, including:

- Overviews of administrative/operational policies and procedures for which physicians/providers are responsible
- Programs and processes of physician/provider evaluation, such as site audits and encounter data
- Benefits and claims administration
- Survey results and member feedback
- Practice and treatment guidelines
- State and federal regulatory guidelines
- Provider interventions and education
- Quality initiatives
- Information on disease management and preventive health programs for members
- Accreditation standards/requirements
- Policies and procedures
- Formulary changes

BCBSRI.com

As part of our ongoing commitment to streamline processes, improve efficiencies, and strengthen communications, we offer our providers a variety of tools and resources to quickly find up-to-date information regarding our healthcare plans, member eligibility, and current policies and procedures. Since access to this information is critical to all aspects of your practice, BCBSRI.com is your one-stop destination for a wide range of information. The majority of this information is only accessible to registered providers and their staff.

Physician/Provider Office Orientations

Upon request, our external provider relations representatives conduct extensive on-site orientations and educational sessions for physicians/providers and their office staff. These sessions provide information on our administrative policies and procedures as well as on our health management and promotion programs.

CHAPTER 3

**PHYSICIAN/PROVIDER
RIGHTS AND RESPONSIBILITIES**

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PHYSICIAN/PROVIDER RIGHTS AND RESPONSIBILITIES

As a BCBSRI physician/provider, you understand how important it is to be aware of the various clinical and administrative aspects of network participation. We expect all physicians/providers to:

- Provide covered benefits in a manner consistent with professionally recognized standards of healthcare;
- Provide professional services in a manner that complies with all laws and requirements, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Social Security Act), Title VI of the Civil Rights Act of 1975, the Americans with Disabilities Act, and all other laws applicable to the receipt of federal funds; and
- Know and observe the policies and procedures related in this chapter, many of which are actively monitored by our quality improvement and medical management programs.

Primary Care Physicians (PCPs)

PCPs are responsible for providing primary care services and managing all of the healthcare services needed by their patients, including the identification, assessment, and establishment of treatment plans for members with serious and complex medical conditions. As the first line of medical defense, personal physicians take a “big picture” view of their patients’ health and lifestyle, and manage the appropriate use of healthcare resources.

Responsibilities of BCBSRI PCPs

As a PCP, you must:

- Deliver all primary healthcare services that do not require specialized care, including:
 - Regular periodic preventive health screenings;
 - Routine preventive immunizations and inoculations;
 - Periodic physical exams consistent with routine preventive care;
 - Medical management of chronic conditions not requiring a specialist;
 - Office visits for illness or injury;
 - Hospital medical visits, including emergency room care when appropriate; or coordination of those services with another BCBSRI physician/provider.
- Provide continuous coverage (24 hours a day, seven days a week).

- Participate in the development of a member's care plan if the member is participating in Care Coordination. After a member's care plan is faxed to your office, you should review it, provide feedback, and fax it back to BCBSRI Care Coordination. Your office will receive \$50 for this collaboration. You must also communicate changes in the member's health status or care plan to the member's Care Coordinator/Nurse Care Manager.
- Freely discuss with members treatment needs and recommend alternatives, regardless of cost, benefit limitations, or BCBSRI administrative policies and procedures.
- Advise members of the risks, benefits, and consequences of treatment or non-treatment and allow members the opportunity to refuse treatment and to express preferences about future treatment decisions.
- Inform BlueCHiP for Medicare members about the different Medication Therapy Management programs offered by BlueCHiP for Medicare. Members who are in a plan that includes Medicare Part D prescription coverage may participate.
- Inform members of any risks involved in their care.
- Advise members in advance if any proposed medical care or treatment is part of a research experiment.
- Provide immediate emergency or urgently needed care or appropriately advise member as to the appropriate facility to obtain care.
- Advise members in advance if a service you are recommending is not covered by their health plan and that they will be financially responsible. Members must also complete and sign an Advance Beneficiary Notice (ABN) form, which can found on BCBSRI.com.
- Prescribe medications to treat routine illness or injury and, when medically appropriate, prescribe generic or formulary medications.
- Ensure that services are provided in a culturally competent manner.
- Inform members of any needed follow-up care and provide patient education and training in self-care as necessary.
- Order medically appropriate diagnostic lab and X-ray services as needed.
- Discuss advance directives with your patients and document in their health records whether or not they have executed one.
- Not discriminate against members in the delivery of healthcare services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, medical condition (such as ESRD), 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.
- When applicable, admit members to a BCBSRI network hospital, rehabilitation facility, or skilled nursing facility for inpatient care. Referrals to out-of-plan facilities must be authorized by BCBSRI in advance, with the exception of

emergency and post-stabilization services or urgently needed services while a member is temporarily out of the service area or, in the case of urgent services, when the personal physician is unavailable.

- Adhere to the following referral and/or plan authorization requirements for members covered by a BlueCHiP plan (See the Appendix for a sample referral form. You can also get forms in the Provider section of BCBSRI.com.):
 - Referrals are not required for members of HealthMate plans.
 - Referrals are not required for members of BlueCHiP for Medicare.
 - Direct and coordinate care for BlueCHiP for Medicare members to participating specialists, healthcare practitioners, and ancillary providers for medically necessary diagnosis or treatment unless services are not available within the network.
 - Observe the following coverage rules for BlueCHiP for Medicare out-of-network services: With the exception of emergency, urgent care, ambulance, and renal dialysis, BlueCHiP for Medicare Core, Standard with Drugs, Plus, and Group Plus members only have access to out-of-network providers if the service is not available in network. To access out-of-network providers in non-emergency situations, prior authorization is required. For BlueCHiP for Medicare Core, Standard with Drugs, Plus, and Group Plus members, services must be authorized by calling BCBSRI Utilization Management at (401) 272-5670. For BlueCHiP for Medicare Value, BlueCHiP for Medicare Preferred, Group Preferred, and Group Preferred Unlimited members, services from out-of-network providers may be available through their Point of Service (POS) benefit. In non-emergency situations, certain covered services under the POS benefit require Plan authorization by calling BCBSRI Utilization Management at (401) 272-5670.

Note: Please refer to the member's coverage plan/Evidence of Coverage for specific exceptions/exclusions.

- Except for BlueCHiP for Medicare, provide the specialist with a referral in writing (by fax, by mail, or through the patient) before your patient receives specialty services. To fulfill coordination of care expectations, these referrals must include your expectation regarding the frequency and mode of communication from the specialist regarding treatment plans and the patient's outcome.
- If the patient does not receive prior authorization for applicable benefits, please notify the patient in advance that she/he will be responsible for paying all or part of the charges, and document such notification in the patient's file. If, after advance notice, the patient still chooses to self-refer, please document this in the patient's file also. BCBSRI will conduct periodic audits for verification of patient acknowledgement of payment responsibility on claims processed as self-

referrals for a service that requires a referral. Lack of documentation will result in a post-service denial.

Radiology Privileging

If you are a provider who renders and bills for radiology services (e.g., X-rays and ultrasounds), you must be privileged and approved by our radiology management vendor, MedSolutions, Inc. (MSI), to be reimbursed by BCBSRI. If you are not privileged and render services to one of our members, your claim will be denied and you may not bill the member for the services, unless you obtain acknowledgement in writing from the member that he/she agrees to pay for the services.

If you are a new provider joining a practice that is already privileged, you will be allowed to bill for the radiology services. If you are already privileged and join a practice that is not privileged, you may not bill for those services until the group has been approved.

You may contact our Credentialing Department by calling (401) 274-4848 or 1-800-230-9050 to initiate the radiology privileging process.

Procedures

A PCP may directly proceed with needed medical services when:

- Ordering diagnostic lab or X-ray services,
- Prescribing medication, or
- Providing services himself or herself.

A PCP must first call BCBSRI Utilization Management & Integration when:

- Referring/directing a member to an out-of-network healthcare practitioner, ancillary care provider, or facility

Specialty Care Physicians/Providers

Specialty care physicians/providers, or specialists, are responsible for the diagnosis and treatment of any condition for which the member was referred/directed by a BCBSRI PCP or for which he/she self-referred. Treatment by a specialist is limited to the specific medical condition or problem for which the member was referred/directed or self-referred, and any medically necessary services related to that condition. Specialty care providers are responsible for managing the condition until it is resolved.

Responsibilities of Specialty Care Physicians/Providers

- Evaluate a member's condition by taking a complete history and performing a physical exam when appropriate.

- Provide services and communicate back to the PCP any changes in the member's health status or care plan.
- Maintain documentation of all communications with the PCP. Please keep in mind that specialists should communicate with the PCP about any treatment provided to patients, regardless of whether or not a formal referral was made.
- In the event the member hasn't selected a PCP, direct him/her to the Find a Doctor tool on BCBSRI.com.
- If a member participates in Care Coordination, communicate any changes in the member's health status or care plan to his or her Care Coordinator/Nurse Case Manager.
- Ensure that services are provided in a culturally competent manner.
- Inform BlueCHiP for Medicare members about the different Medication Therapy Management programs offered by BlueCHiP for Medicare. Members who are in a plan that includes Medicare Part D prescription coverage may participate.
- Inform members of any risks involved in their care.
- Advise members in advance if any proposed medical care or treatment is part of a research experiment.
- Not discriminate against members in the delivery of healthcare services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, medical condition (such as ESRD), 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.
- Inform members of any needed follow-up care and provide patient education and training in self-care as necessary.
- Freely discuss treatment needs and recommended alternatives with members, regardless of cost, benefit limitations, or BCBSRI's administrative policies and procedures.
- Advise members of the risks, benefits, and consequences of treatment or non-treatment and allow them the opportunity to refuse treatment and to express preferences about future treatment decisions.
- Advise members in advance if a service you are recommending is not covered by their health plan and that they will be financially responsible. Members must also complete and sign an Advance Beneficiary Notice (ABN) form, which can be found on BCBSRI.com.
- Provide immediate emergency, post-stabilization, or urgent care.
- Deliver all healthcare services that are due to or related to the condition for which a member seeks care or has been referred, such as:
 - Office visits for diagnosis or treatment
 - Medical management

- Hospital medical visits, including emergency and post-stabilization care when appropriate, due to the condition or a related complication
- Prescribe medications for the condition being treated, prescribing generic or formulary medications as medically appropriate, and communicate all changes to the PCP to ensure good coordination of care.
- If necessary, order medically appropriate diagnostic services for the condition being treated.
- When applicable, refer/direct a member to a network hospital, a rehabilitation facility, a skilled nursing facility, an outpatient surgical facility, or ancillary providers when medically necessary to treat the member's condition, unless the member requires emergency or post-stabilization care while temporarily outside the service area.

In addition, specialists must adhere to the prior authorization process for members covered by a BlueCHiP plan:

- Except for BlueCHiP for Medicare members, obtain a **written** PCP referral as appropriate before rendering non-emergency specialty services in network, and maintain the referral form in the patient's records. If you do not receive a referral, please notify the patient in advance that she/he will be responsible for paying all or part of the charges, and document such notification in the patient's file.
- If, after advance notice, the patient still chooses to self-refer, please document this in the patient's file also. BCBSRI will conduct periodic audits for verification of patient acknowledgement of payment responsibility on claims processed as self-referrals for a service that requires a referral. Lack of documentation will result in a post-service denial.
- Initiate ongoing communication with the patient's PCP about the patient's treatment plan and its outcome, as requested by the PCP's referral.
- Determine when a member requires the services of other participating specialists, healthcare practitioners, or ancillary providers for further diagnosis or more specialized treatment of the condition for which the member was referred, or a related complication. In such instances, refer the patient back to the PCP since a written PCP referral must be obtained for services performed by another specialist.

Radiology Privileging

If you are a provider who renders and bills for radiology services (e.g., X-rays and ultrasounds), you must be privileged and approved by our radiology management vendor, MedSolutions, Inc. (MSI), to be reimbursed by BCBSRI. If you are not privileged and render services to one of our members, your claim will be denied and you may not bill the member for the services, unless you obtain acknowledgement in writing from the member that he/she agrees to pay for the services.

If you are a new provider joining a practice that is already privileged, you will be allowed to bill for the radiology services. If you are already privileged and join a practice that is not privileged, you may not bill for those services until the group has been approved.

You may contact our Credentialing Department by calling (401) 274-4848 or 1-800-230-9050 to initiate the radiology privileging process.

Procedures: For Members of Commercial BlueCHiP Coordinated Health Plans

- A specialist must confirm that members have been referred/directed by their PCP.*
- The specialist must proceed with requested medical services as defined by the PCP's referral.

If it is medically necessary to refer a member to another physician/provider:

- The specialist must proceed with needed medical services if they are diagnostic lab or X-ray services consistent with the services the specialist will be providing, or if the specialist is prescribing medication.
- If referring to another physician/provider for other than diagnostic services, the specialist must call the PCP to discuss the need for another referral. This will allow the PCP to update the member's medical records and ensure continuity of care.
- The PCP must provide any additional referrals.
- Specialist-to-specialist referrals are not allowed.

Please note: Behavioral health does not require any referrals.

All Physicians and Providers

BCBSRI Confidentiality Statement

BCBSRI employees and agents will protect the privacy and confidentiality of our members' healthcare information. We will maintain, use, and disclose confidential health information as permitted or required by applicable state and federal laws, such as the Rhode Island Confidentiality of Health Care Communications and Information Act, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We will have in place administrative, technical, and physical safeguards to protect the privacy and security of our members' health information.

Protected health information is information that relates to an individual's past, present, or future physical or mental health or condition, or the past, present, or future payment for the provision of healthcare to an individual, including demographic information, received from or on behalf of a healthcare physician/provider, health plan, clearinghouse, or employer, that either identifies the individual or could be reasonably used to identify the individual. It includes such information contained in any form or medium (electronic, paper, oral, etc.).

BCBSRI Employee Access

All BCBSRI employees are trained in confidentiality and our privacy and security policies and procedures upon hire, and are required to read and sign a confidentiality statement upon hire and then yearly thereafter. To further protect the privacy of our members' health information, employees' access to health information is limited to only that information which they need to do their job. Any employee who violates the confidentiality policy will be subject to disciplinary action.

Member Access

BCBSRI members have the right to access their own health information/medical record and the right to request an amendment of their health information in accordance with the Rhode Island Confidentiality of Health Care Communications and Information Act. Our Notice of Privacy Practices describes additional rights in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy provisions.

Non-Discrimination

As a BCBSRI participating provider, you shall not discriminate against members in the delivery of healthcare services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, medical condition (such as ESRD), 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.

Participating Physician/Provider Sites

Physicians/providers are responsible for maintaining the privacy, confidentiality, and security of their patients' health information in accordance with applicable state and federal laws. Medical records must be in a secure area with access limited to authorized personnel. Effective record-keeping practices must be in place to protect the integrity and privacy of their patients' health information.

Special Responsibilities Regarding Members of BlueCHiP for Medicare

All BCBSRI physicians/providers (both PCPs and specialists) who treat BlueCHiP for Medicare patients are responsible for ensuring that no member of their medical staff is debarred by the Office of the Inspector General, sanctioned by Medicare, or has opted out of Medicare.

BlueCHiP for Medicare members may not receive medical care from providers sanctioned by Medicare or those who have opted out of Original Medicare except in emergency or urgent care situations. This issue is examined during all reviews, including credentialing and recredentialing, and monthly thereafter.

The following are guidelines from The Centers for Medicare and Medicaid Services regarding a provider's role in a member's Medicare plan selection:

1. Provider Activities and Materials in the Healthcare Setting

Providers contracted with a Plan are permitted to:

- Engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options.
- Provide the names of plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the low income subsidy.
- Provide objective information on ALL plan sponsors' specific plan formularies, based on a particular patient's medications and healthcare needs.
- Provide objective information regarding ALL plan sponsors' specific plans being offered, such as covered benefits, cost sharing, and utilization management tools.
- Distribute all Part D Prescription Drugs Plans' (PDP) marketing materials with whom the provider contracts with, including enrollment application forms.
- Make available and/or distribute plan marketing materials for all plans with which the provider participates (including PDP enrollment applications, but not MA or MA-PD enrollment applications).

Providers should also inform prospective enrollees where they may obtain information on the full range of plan options. Because providers are usually not fully aware of all Medicare plan benefits and costs, they are advised to additionally refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, www.medicare.gov, or 1-800-MEDICARE.

The "Medicare and You" Handbook or "Medicare Compare Information" (from www.medicare.gov) may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by the Centers for Medicare and Medicaid Services (CMS) or have been previously approved by CMS. These materials may be distributed by plans and providers without further CMS approval. *This includes CMS Plan Finder information via a computer terminal for access by beneficiaries.*

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. **Therefore, it would be inappropriate for providers to be involved in any of the following actions:**

- Offer sales/appointment forms;
- Accept enrollment applications for Medicare Advantage, Medicare Advantage Prescription Drugs Plans, or Part D PDPs;

- Direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests;
- Mail marketing materials on behalf of plan sponsors;
- Offer anything of value to induce plan enrollees to select them as their provider;
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization;
- Health screen when distributing information to patients, as health screening is a prohibited marketing activity; and
- Accept compensation directly or indirectly from the plan for beneficiary enrollment activities.

- 2. Plan Activities and Materials in the Healthcare Setting** – While providers are prohibited from accepting enrollment applications in the healthcare setting, plans or plan agents may conduct sales presentations and distribute and accept enrollment applications in healthcare settings as long as the activity takes place in the common areas of the setting and patients are not misled or pressured into participating in such activities. Common areas, where marketing activities are allowed, include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

Plans are prohibited from conducting sales presentations and distributing and accepting enrollment applications in areas where patients primarily intend to receive healthcare services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medications).

Only upon request by the beneficiary are plan sponsors permitted to schedule appointments with beneficiaries residing in long-term care facilities. Additionally, providers are permitted to make available and/or distribute plan marketing materials as long as the provider and/or the facilities distributes or makes available plan sponsor marketing materials for all plans with which the provider participates. Providers are also permitted to display posters or other materials within the long-term care facility announcing all plan contractual relationships.

- 3. Provider Affiliation Information** – Providers may announce new affiliations and repeat affiliation announcements for specific plans through general advertising (e.g., publicity, radio, television). An announcement to patients of a new affiliation which names only one plan may occur only once when such announcement is conveyed through direct mail and/or email. Additional direct mail and/or email communications from providers to their

patients regarding affiliations must include all plans with which the provider contracts. Provider affiliation banners, displays, brochures, and/or posters located on the premises of the provider must include all plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS.

- 4. Comparative and Descriptive Plan Information** – Providers may distribute printed information provided by a plan sponsor to their patients comparing the benefits of different plans (all or a subset) with which they contract. Materials may not “rank order” or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution. Providers may not health screen when distributing information to their patients, as health screening is a prohibited marketing activity.
- 5. Comparative and Descriptive Plan Information Provided by a Non-Benefit/Service Providing Third Party** – Providers may distribute printed information comparing the benefits of different plans (all or a subset) in a service area when the comparison is done by an objective third party.
- 6. Providers/Provider Group Websites** – Providers may provide links to plan enrollment applications and/or provide downloadable enrollment applications. The site must provide the links/downloadable formats to enrollment applications for all plans with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center.
- 7. Health Fairs** – Providers may distribute plan marketing materials (including Prescription Drug Plan enrollment applications, but not Medicare Advantage or Medicare Advantage-Prescription Drug enrollment applications) and generally educate potential enrollees at health fairs. Providers cannot compare benefits among plans in this setting because they may not be fully aware of all benefits and costs of the various plans.
- 8. Leads from Providers** – Plans and providers are responsible for following all Federal and State laws regarding confidentiality and disclosure of patient information to plan sponsors for marketing purposes. This obligation includes compliance with the provisions of the HIPAA privacy rule and its specific rules regarding uses and disclosures of beneficiary information. In addition, plans are subject to sanction for engaging in any practice that may reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose medical condition or history indicates a need for substantial future medical services (i.e., health screening or “cherry picking”).

9. Identifying Enrollees – Physicians/providers and physician groups are prohibited from furnishing any information that identifies a particular enrollee when:

- The information comes from the election of a Medicare Advantage plan.
- The information is being furnished for purposes unrelated to the plan.

Patient Access

Safe and easily accessible practice sites and efficient office management are essential for ensuring high-quality care and services. All BCBSRI physicians/providers must ensure that they provide convenient, timely, and safe access to needed medical care. We work with all our participating physicians/providers to help bring their physical premises and operating procedures to the highest possible level.

Access Standards

BCBSRI measures member access by specific standards based on indicators for convenience, timeliness, and safety. We monitor compliance with access standards and incorporate it into our quality improvement activities. Regulatory agencies, such as the Rhode Island Department of Health and Rhode Island Department of Human Services, and accrediting organizations, such as the National Committee for Quality Assurance (NCQA), also place great emphasis on member access.

BCBSRI measures accessibility and premise capabilities by the following standards:

Office hours – Each personal physician practice site must be open a minimum of three days and 20 hours each week, unless fewer hours have been approved by BCBSRI.

After-hours coverage – All physicians will provide for continuous coverage, 24 hours a day, seven days a week. Phone calls received by office staff should be returned the same day. After-hours calls should be returned within one hour. Physicians must be available by telephone after usual office hours. An answering machine alone is not acceptable unless it provides an emergency phone number for patients to contact the physician. Calls must be responded to by the on-call clinician within one hour of the time they were placed by the patient.

Covering physicians – A covering physician must be available whenever the personal physician is not available.

The following coverage requirements apply to both medical and behavioral healthcare providers:

- All physicians/providers must have at least one person other than themselves for coverage in the event of illness or absence from the service area. Cell phone use

when out of the area is not reliable. Coverage arrangements must be in place in case face-to-face contact with the member is necessary.

- Coverage may be performed personally or through the use of an appropriately qualified professional(s) who is either contracted and credentialed by BCBSRI or meets all qualifications and agrees to be bound by the same administrative and contractual obligations.
- A non-physician may cover a physician, as long as the appropriate level of service can be provided and the non-physician has back-up physician supervision or collaboration for consultation, as needed.
- Coverage must reflect appropriate qualifications for the specialty.

Interpreter services for BlueCHiP for Medicare members – BlueCHiP for Medicare members are entitled to on-site interpreter services during medical visits. Language interpreter services are provided for non-English speaking members. Sign language services are covered benefits for members who are hearing impaired. These services are not available in an inpatient hospital or surgical-center setting. We have contracted vendors who provide on-site language and sign language interpreters. If your BlueCHiP for Medicare patient needs interpreter services, call the Physician and Provider Service Center at (401) 274-4848 to make arrangements. Advance notification is required. Language interpreter requests must be made 72 hours prior to the date of service. Sign language services must be requested 3 weeks in advance of the date of service.

Appointment wait times – Appointments must be available daily during regular office hours. Appointment times must be left open daily for emergencies and urgent care, unless the staff can add appointments without disrupting patient flow. In-office wait times should be 30 minutes or less, with the exception of same-day urgent visits, which may have a longer wait time. Wait times for services must meet the standards below.

- **Emergency care:** Patient must be seen immediately, or referred as medically appropriate.
- **Urgent care:** Patient must be evaluated within 24 hours of the request for services (preferably the same day, or next day, if physician is contacted in the evening).
- **Routine primary care appointments (non-emergent, non-urgent, symptomatic):** Appointment must be made within 14 days (within one week for BlueCHiP for Medicare members, effective January 1, 2007) according to BCBSRI's access standards (or earlier, if condition warrants).
- **Routine care appointments for behavioral health:** Appointments must be made within 10 business days.
- **Preventive care:**
 - o PCPs – Within two months (within 30 days for BlueCHiP for Medicare members), including preventive gynecologic exams.

- o OB/GYNs and certified nurse midwives – Within four months (unless credentialed as a PCP, in which case PCP standard applies).
- ***For breastfeeding newborns:*** Within 10 days of birth.
- ***For all other newborns:*** Within 30 days of birth.
- ***Prenatal visits:*** Within first trimester (by the twelfth week as calculated by last menstrual period) unless the member calls after the twelfth week, then appointment must be scheduled within one week.
- ***New patients:*** Appointment must be made within 30 days of selection of new PCP, including when this occurs at enrollment. In addition, a history must be obtained and a physical performed by the third visit.

Behavioral healthcare – Non-emergent, non-urgent behavioral health appointments must be available within 10 business days for BlueCHiP Coordinated Health Plan and BlueCHiP for Medicare.

Guidelines for the Return of Calls Requirements for All Practitioners

- ***Calls triaged by office staff:*** Same day
- ***Off-hours calls:*** In one hour
- ***Emergency room calls:*** In 30 minutes

Physical Accessibility

All practice sites must comply with the specifications of the Americans with Disabilities Act (unless qualified for exceptions according to the law), including:

- The building must have a wheelchair ramp or suitable alternative, such as assistance provided by the office staff. A provider visiting with a handicapped member at an alternate location is also acceptable.
- Any water fountain must be at wheelchair level or water must be available by other means.
- If the physician office is above or below entry level, there is an elevator in the building/office. Other types of arrangements, such as a wheelchair lift, are acceptable.
- There is designated parking for people who are handicapped. If there is only street parking, there must be evidence of an attempt to designate parking in front of the building, even though the community may have rejected the request.
- Bathrooms must be handicapped-accessible, or alternative access must be available.

Waiting area – The waiting area must have adequate space. (Rule of thumb: a minimum of four chairs per physician or mid-level practitioner working at the same time.)

Exam rooms – The practice site must have examination space adequate for patient scheduling: at least two private exam rooms or other acceptable space available to each physician or mid-level practitioner working at the same time.

Physician office – At least one office or other acceptable space (one that affords patient privacy) must be available for each physician working at the same time.

Site Safety

The practice site must be designed, constructed, equipped, and maintained in a manner that provides for the physical safety of patients, visitors, and staff.

The site must be:

- Identified as a medical building; if not, the staff must identify it as being unmarked when members call for appointments
- Clean, with surfaces that are regularly disinfected
- Well lit, with visible exit sign(s)
- Structurally sound: No plaster or paint chipping on walls, no leaks in roof, no exposed, split, or loose wires

The site must have:

- Readily accessible hand-washing facilities
- Readily available equipment/supplies for performing exams (e.g., gloves, gauze)
- Secure stairways, with railings
- A lit parking lot, if the office keeps evening hours
- An easily accessible fire extinguisher, as well as a written fire protection policy (or one that the staff can communicate verbally)
- A written safety hazard policy (or one that the staff can communicate verbally)
- An infection control policy that is in effect and signed by all employees
- Acceptable infection control practices are maintained, as evidenced by (but not limited to):
 - Isolation precautions, if applicable
 - Biohazard containers in exam rooms
 - Gloves available in exam rooms
 - Sterilization equipment, directions for use, and quality checks documented, as applicable (Sterilization is the use of a physical or chemical procedure to destroy all microbial life, including highly resistant bacterial endospores.)
 - Handwashing facilities

The site's staff must:

- Report and investigate all accidents and injuries relating to safety hazards
- Have working knowledge of equipment used by patients and/or other staff members, including effective management of selection, delivery, setup, and maintenance

Medication Safety

Medications must be safely stored to protect unauthorized access. Here are additional medication safety practices that must be followed:

- Prescription pads and sample drugs must be kept in locked storage, with access granted to authorized personnel only.
- Medications and biologicals requiring refrigeration must be stored separately from food or lab specimens.
- All sample drugs must be destroyed by their expiration date.
- Oral and topical medications must be stored separately.
- Needles and syringes must be stored in a secure area away from patient access (if stored in cabinets in exam areas, cabinets must be locked).
- There must be a written policy and procedure for the storage and dispensing of medications and handling of patient requests on prescriptions (or one that the staff can communicate verbally).

Lab Safety

Practice sites with laboratory facilities must be able to ensure the safety and regulatory compliance of lab services.

- Individuals performing tests must be qualified and licensed.
- A Certified Laboratory Institute Association (CLIA) license must be posted, or the license number made available.
- There must be a written policy on the proper handling and disposal of biohazardous waste (or one that the staff can communicate verbally).
- Gloves and protective eyewear must be used for drawing blood, and then properly disposed.
- Blood and/or infectious materials must be placed in a leak-proof container for transportation.

Medical Records

A medical record must be created for every member treated or seen by the physician/provider. Medical records are confidential, and must be securely stored, with safeguards in place to prevent unauthorized or inadvertent use or disclosure of the information. We have developed standards for the confidentiality, security, content, and

continuity of these records. They will help you practice more effectively and efficiently, documenting the overall quality of the care and service you provide. Medical records must be retained in accordance with generally accepted standards and applicable laws and regulations.

Compliance Measurements

BCBSRI uses the following measurements to evaluate compliance with security and confidentiality standards:

- Medical records must be kept in a secure manner that ensures confidentiality, in an area away from patient access but easily accessible by physician and staff.
- Office site must have a written confidentiality policy that is signed by all employees and
- Evidence that staff receives periodic training on confidentiality of member information.
- Adequate measures are in place to physically safeguard medical records from loss by fire, water, and foreseeable sources of potential damage.
- A tracking mechanism is in place to reduce risk of lost or misfiled records.
- Electronic medical record safeguards include, but are not limited to:
 - Electronic backup
 - Unique user identification for authorized personnel
 - Ability to generate audit logs
 - Screens that can't be viewed by others
- A healthcare provider with a direct treatment relationship with an individual must provide the individual with a Notice of Privacy Practices that includes:
 - The provider's uses and disclosures of protected health information
 - The individual's rights with respect to protected health information
 - The provider's legal duties with respect to protected health informationExcept in emergency situations, the provider must obtain a written acknowledgement of receipt of the notice. If not obtained, the provider must document the attempt to obtain one, and the reason the acknowledgement was not obtained.
- A Notice of Privacy Practices is posted in a clear and prominent location where it is reasonable to expect individuals (clients/patients) to be able to read the Notice. (If the notice is not in the waiting area, it should be in each of the exam rooms.)
- Providers must have a staff member designated as a privacy officer to be responsible for responding to a patient's concern or complaint about the office's confidentiality or privacy practices.
- Staff has knowledge about release of information standards.
- All medical record entries must be dated, legible, in sequential order, and signed or initialed by the physician or whoever has made the entry.

Medical Records Standards

Members' medical records must contain, at a minimum, the following:

General information

- Patient's identification (full name or ID number) on all pages.
- Patient's personal and biographical data (address, home/work telephone, date of birth, marital status).
- Name, relationship, address, and telephone number of next of kin or other responsible person.
- A problem list.
- A complete list of medications. Allergies and adverse reactions to medications should be highlighted.
- Whether or not the patient has executed an advance directive.
- All notes, consultation summaries, and laboratory and imaging reports. These must be initialed by the physician or stamped "reviewed."

Please note:

- All medical record entries must be dated and in sequential order.
- All records must be legible.

Medical history

- Past medical history for patients seen three or more times.
- Family medical history (patients aged 65 and younger).
- Immunizations.

For pediatric patients, please include all of the information above, plus:

- The name, address, and phone number of a parent, guardian, or other responsible adult, and that person's relationship to the patient.
- A birth history, including location and birth weight.
- A growth chart listing head circumference (up to age 2), height, weight, and BMI percentile or, for patients who are 16 or older, BMI.
- Up-to-date immunization records.

Availability

As a BCBSRI physician/provider, you are required to cooperate with requests to provide members' medical records. A review of these records allows BCBSRI to identify needed improvements in record-keeping practices and evaluate the quality of care and appropriateness of services members receive. We also use these records to determine the overall health status of our members and develop new programs for prevention and treatment, to help support physician practices. Upon request by BCBSRI or CMS, you must be willing and able to certify that the medical records and the claims or encounter data derived from them are accurate, complete, and truthful.

Circumstances Requiring Medical Records

- The organization has access to practitioner medical records, to the extent permitted by state and federal law.
- BCBSRI requires medical records for these quality management, utilization management (UM), and regulatory compliance purposes.
- For the credentialing process, to ascertain physicians' conformity to BCBSRI standards for record keeping.
- During preauthorization, case management, and/or complaints and appeals processes, to determine the medical necessity of medical services and coordination of care, and to ascertain the physician's conformity to BCBSRI standards for record keeping.
- For audits performed in connection with quality improvement studies and the Healthcare Effectiveness Data and Information Set (HEDIS[®]) data collection for BCBSRI's overall quality of care.
- Regulatory/accreditation reviewer requests.

The use of members' medical records is permitted by HIPAA, and is governed by BCBSRI's corporate policies and procedures on confidentiality.

Release of Records

BCBSRI may request a member's medical records from a physician/provider for administrative reasons such as the evaluation of quality of care, utilization of services, payment of claims, and resolution of disputes related to healthcare services. Information may be required to respond to regulatory requests, for coordination of care purposes, to third-party health insurers for adjudication of claims, for medical peer review such as for use in credentialing or use in quality improvement activities. When we request information for these purposes, or for other purposes that are part of our healthcare operations, these disclosures are permitted by HIPAA, and a written authorization from the patient(s) is not needed.

Documentation of the release of your patients' medical records must be maintained. Written authorization to release health information is not required when forwarding information to referring physicians/providers or specialists or for other treatment-related purposes. However, if you need the records of a new patient, or you must forward the records of a patient who has left your care, we recommend that you obtain written permission from the member.

Procedures

When providing a member's medical record to BCBSRI:

- **Be sure to understand the purpose of the request.** An appropriate BCBSRI staff person will explain why the records are needed and give you instructions on releasing them. We will only request the minimum amount of information that we need for the particular purpose. Personal physicians/providers and specialists do not need a written authorization from their patient to release information to us.
- **Cooperate with instructions for delivery.**
 - Follow mailing instructions, fax, or have the records available for pick-up by courier and direct delivery to BCBSRI. Because of the confidentiality and security issues involved, we will not ask you to fax documents, except in some urgent cases.
 - Provide copies, not originals. Let us know if materials must be returned (otherwise, they will not be).
 - BCBSRI does not reimburse providers for costs incurred when releasing records.

Charges for Medical Records

While BCBSRI will not reimburse providers, the Rhode Island Department of Health regulations state that providers may charge patients up to \$15 to retrieve a record and up to \$.25 per page to reproduce it (\$.10 per page after 100 pages). You may pass along the actual cost of reproducing X-rays and other documents that cannot be photocopied, plus up to \$15 for any clerical work involved. Regulations also indicate that requests must be made in writing, and filled within 30 days of receipt of the request. If records are required within 48 hours, you may charge a special additional handling fee of \$10.

Transfer of Medical Records

Providers are responsible for transferring a member's medical records when the member transfers to another provider. The transfer of medical records must be done in a timely manner to avoid any disruption in a member's healthcare. Terminating physicians must inform BCBSRI of all members who are currently in the course of active or acute treatment. We will help those members make the transfer to a new physician with as little disruption to their care as possible.

Specialists and specialty group practices require timely notification to the organization members affected by the termination of a specialist or the entire specialty group. When appropriate, BCBSRI will provide onsite assistance with compiling records and arranging their transfer.

Time Frames

Record transfers should be completed by the effective date of the enrollment transfer or network termination. Until the transfer or termination becomes effective, you are required to continue treating the member as needed.

Reporting

BCBSRI is contractually obligated to report to government agencies various kinds of information about members and/or the healthcare services they receive. Your timely collection of data helps us to meet these requirements.

It is important that our information on physicians'/providers' practices is accurate and up-to-date; therefore, participating providers are required to inform BCBSRI of any changes affecting member access to care and services.

Practice Changes to Report

Practice Locations

BCBSRI has established standards for geographic access by members to personal physicians; a relocation may affect member accessibility.

If a personal physician is relocating, members may select a new PCP. We will notify the physician of any enrollment changes resulting from the relocation.

Specialty care physicians are also required to notify us of practice relocations so that we can give members up-to-date information.

Personal physicians, OB/GYNs, and selected high-volume specialists require a site visit after relocation; other providers will be notified if the new office location requires a site review. (This is not applicable for practices that are part of a patient-centered medical home.)

All practice changes should be reported by completing the appropriate forms and sending them to BCBSRI so that the necessary updates can be made. For your convenience, a Practitioner Change Form and Substitute W-9 Form are included in the Appendix and are also available on the Provider section of BCBSRI.com. Also, it is essential that we have your current email address as we send important information for your practice via email. Please provide your current email address on the Email Address Update Form and mail it or fax it to BCBSRI. This form is included in the Appendix and is also available in the Provider section of BCBSRI.com.

Change of Phone Number(s) or Reduced Practice Hours

These changes have a direct impact on member access, as well as BCBSRI's ability to communicate with the physician/provider. We will publish the new number(s) and/or hours in the next available edition of the BCBSRI provider directory. Members who call BCBSRI will be given the new information as soon as the changes take effect.

Providers should complete either the Practitioner Change Form or contact the Physician and Provider Service Center to inform BCBSRI of the change.

Voluntary Network Participation Terminations

All providers voluntarily terminating their network participation are required to notify BCBSRI. A 60-day advance notice is a contractual obligation. This is particularly important for personal physicians, as their members must transfer to another provider. If you are a PCP and do not provide BCBSRI with the name of the physician who will assume the care of your assigned members, we will contact your office to discuss a smooth transition of care.

Reasons for voluntary network participation terminations include, but are not limited to, relocations outside the service area, retirement, or when a practice is to be closed. For your convenience, a Voluntary Termination Form is located in the Appendix and is also available on the Provider section of BCBSRI.com.

Per Chapter 4 of the Medicare Managed Care Manual, BCBSRI as a Medicare Advantage organization must make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, regardless of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified. Please note that BCBSRI must first submit the termination letter that will be sent to members to CMS for up to a 45 calendar day review and approval.

It is not considered a termination if you are leaving a location, but will remain participating at another location. In those cases, you should complete a Practitioner Change Form.

Non-Interruptive Changes

While some practice changes do not affect the continuity or coordination of member care, we ask that you notify us of any changes to your practice as soon as you are aware of them, or at least 30 days in advance. This will allow us to update our systems and to provide members with the most complete, up-to-date information available. Non-interruptive changes include the addition of more phone lines and expanded practice hours.

Procedures

To notify BCBSRI of changes to your practice including practice location, hours, or a change in phone number:

Please call the Physician and Provider Service Center to obtain a Practitioner Change Form and a Substitute W-9 Form as soon as you are aware of the change. Examples of these forms are included in the Appendix of this manual. You can also get forms at the Provider section of BCBSRI.com. We ask that you notify us at least 30 days in advance of the change to allow us sufficient time to update our system.

Notify patients of the change as appropriate. The following procedures meet BCBSRI standards for advance notification:

Phone number changes – Standard telephone company response when the old number is dialed, for a period of no less than six months

Reduced practice hours – Notice posted in the office waiting area; written notice mailed to all patients, and a telephone voice response message

To notify BCBSRI of practice capacity limitations or temporarily closed practices:

Call the Physician and Provider Service Center to obtain our Practitioner Change Form as soon as you are aware of the change.

If your practice closes temporarily, our Customer Service Department will direct inquiring members to other providers. It is not necessary to notify patients directly.

To notify BCBSRI of voluntary participation terminations:

Mail or fax a notice of termination no less than 60 days prior to the effective date.

A provider database associate will review the termination request, including transitioning the members to another provider. We will inform our Customer Service Department so that members may be notified of the change.

IMPORTANT NOTE: If you are no longer able to treat an established patient because of circumstances beyond your control (such as health or personal tragedy), please call the Physician and Provider Service Center and provide us with as much advance written notice as possible of practice phase-down, preferably as much as 90 days. Established patients must be reassigned to another provider with as little disruption as possible to their care. In this event, Customer Service and/or the Physician/Provider Relations representative will work with you to develop a plan to transfer established patients to another provider. We appreciate your cooperation in developing and activating this plan.

Outpatient Encounter Data

BCBSRI physicians/providers are required, on a regular basis, to provide us with accurate data (encounter data) on services provided to our members in an office setting. We use this information to compare year-to-year changes in health status, both positive and negative. We consider these comparisons when developing our quality improvement programs. Other reasons for the collection of this data include:

Medicare Regulations – The Centers for Medicare & Medicaid Services (CMS) regulations require us to report certain encounter data for BlueCHiP for Medicare members. CMS uses this data to determine payment rates, evaluate quality of care, and educate Medicare beneficiaries. The encounter data is collected through the claims process.

HEDIS® – The Healthcare Effectiveness Data and Information Set (HEDIS) are standardized performance measures designed to ensure that consumers and purchasers of health plans have the information they need to reliably compare the performance of managed care plans. It is sponsored and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to evaluating and reporting on the quality of managed care plans. HEDIS data, combined with NCQA's accreditation program, provide a complete view of health plan quality and a helpful guide to competing plans. NCQA modifies the HEDIS measures annually and makes them available to interested organizations.

Infectious Diseases

In accordance with state regulations, all physicians/providers licensed in Rhode Island are responsible for reporting certain diseases, whether confirmed or suspected. Depending on the severity and communicability of the disease, it must be reported by mail, phone, or electronic means, within a prescribed time period.

Programs Available to Members

Commercial and BlueCHiP for Medicare Programs

With the help of our disease and case management programs, thousands of members each year learn how to maintain and improve their health. Educational information, compliance reminders, and preventive care reminders are offered through our programs and special events. Your cooperation is essential to reaching out to the people who need these programs the most, so please refer eligible members.

Care Coordination Support

Medical and behavioral health case managers provide support over the telephone to members who are dealing with complex health issues. Some examples of situations in which case managers can assist include:

- Catastrophic conditions/injuries requiring coordination of multiple services for long-term care (e.g., severe brain injuries, multiple traumas with significant residuals, spinal cord injuries)
- Frequent ER usage
- High-risk neonates requiring coordination of multiple services
- Pre-term/low-weight infants with complications/complex needs
- Frequent hospital readmissions
- Multiple active diseases
- Non-compliance with medical regimen, with an acute or chronic illness
- Pediatric complex
- Transplants (Adults and children)
- Social/environmental situations and/or other barriers to health and wellness
- Neurological conditions
- Oncology (Adults and children)
- Migraines/chronic pain/fibromyalgia
- GI/Crohn's/ulcerative colitis/GERD
- Rare diseases (e.g., sickle cell anemia, Gaucher's, lupus, hemophilia)
- Wounds resistant to treatment
- Cerebral vascular accident (CVA)/stroke
- Chronic kidney disease/ESRD
- Depression
- Bipolar disorder
- Substance abuse
- Eating disorders

In addition to Care Coordination, we offer Disease Management programs designed to specifically assist members in managing asthma and diabetes. To make a referral to any of our programs, call our triage line at (401) 459-2273. Our hours of operation are 8:00 a.m. to 4:30 p.m., Monday through Friday.

Other Government Programs

Department of Children, Youth and Families (DCYF)/Elderly Affairs (DEA)

Physicians/providers who become aware that a member may be subject to known or potential harm, negligence, or abuse must report the case to the appropriate state agency.

DCYF Abuse Hotline: 1-800-742-4453

Elderly Affairs Abuse Line: (401) 462-0555

Procedures

To provide encounter data for BCBSRI members, submit a claim for all ambulatory services. Use the applicable CPT-4[®] code for each service as though claiming fee-for-service reimbursement. For example, for an office visit for illness including lab work, use both the office visit code and the lab service code. The lab services and office visit will be reimbursed as a claimable expense.

IMPORTANT NOTE: This procedure applies to all physicians/providers, including those whose services are compensated under capitation arrangements.

BCBSRI's Reporting Requirements

In accordance with government regulations, BCBSRI provides the Centers for Medicare & Medicaid Services (CMS) with information on quality and performance issues, including:

- Disenrollment rates*
- Patient satisfaction and health outcomes
- Utilization control procedures
- Availability and accessibility of services
- Financial condition of BCBSRI
- Summary of provider compensation arrangements
- Developments in the health status of enrollees
- Statistical data of grievances and appeals

**CMS is currently receiving disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous two years.*

BCBSRI also has an obligation to provide its BlueCHiP for Medicare members with the following information:

- At least 30-day notification of their personal physician's or specialist's disaffiliation and their rights in such events
- At least 30-day notification of changes in benefits, services, or service area
- Annual notice of benefit, plan, policy, and/or premium changes effective the first of the following year (to be communicated to members via the Annual Notice of Changes (ANOC) letter and Evidence of Coverage (EOC) document. The EOC is issued annually, at the time of enrollment, or upon a plan change.)
- Provider directory annually
- At least 60-day notification of the effective date of negative formulary changes that impact the member (if applicable to plan type)
- Pharmacy Director annually (if applicable to plan type)
- Formulary annually (if applicable to plan type)

BlueCHiP for Medicare members also have the right to get information from us about BCBSRI and their BlueCHiP for Medicare health plan.

This information includes:

- How we control the use of services and costs;
- The number of appeals and grievances filed by our members and the plan's performance rating;
- A summary description of how we pay our doctors, as well as the qualifications of the providers and pharmacies in our network;
- Information on our financial condition; and
- Information on how to exercise plan options.

Provider Administrative Complaints and Appeals

BCBSRI will make every reasonable effort to resolve administrative complaints and appeals from our physicians/providers, following our standard procedures. Resolution of these issues is guided by contractual agreements between BCBSRI and our participating physicians/providers, as well as our own administrative policies and procedures. Provider *administrative complaints* and *appeals* and provider *medical appeals* are handled by the Grievances and Appeals Units (GAU). This section focuses on the procedures for filing and resolving complaints and appeals from providers regarding provider issues. For information on the **member complaints and appeals process**, including how to file a complaint or appeal on behalf of a member, please refer to Chapter 5.

Role of the Physician and Provider Service Center in the Complaint and Appeals Process

The Physician and Provider Service Center is the primary contact for physicians/providers throughout the resolution process for these issues. The Provider Service Representative is responsible for contacting internal BCBSRI departments to discuss the issue and seek resolution based on contractual obligations between BCBSRI and the physician/provider as well as BCBSRI policies and procedures.

A proposed solution is initially presented to the physician by phone. If dissatisfied, a Provider Service Representative will forward the complaint or appeal to the GAU for resolution.

Quality of Care Issues – We identify occurrences of actual or potential poor quality through our staff, members, regulators, providers, and delegated organizations. Quality of care complaints are handled by the Quality Management Department. Types of quality issues include:

- Misdiagnosis, incomplete assessment or evaluation, or performing the wrong procedure

- Site or medical review indicates inappropriate treatment, lack of informed consent, or failure to provide necessary services (including preventive health), or inadequacy of facilities
- Over- or under-utilization patterns such as not referring members for mammography, Pap smears, or immunizations, or inappropriate prescribing of antibiotics
- Potential preventable sentinel events such as metastatic breast cancer or unplanned readmissions where there is an indication of deficient care
- Concerns about possible provider impairment

Provider Administrative Complaint Process

A provider complaint is an oral or written expression of dissatisfaction by the provider regarding an actual or alleged circumstance that gives the provider cause for protest, such as dissatisfaction with any of the following:

- Timeliness of payment
- Payment policies
- Corporation materials
- Timeliness of responses to requests for information.

This complaint process is available to all physicians/providers who are dissatisfied with some aspect of the Plan.

Complaints may be filed with BCBSRI by contacting the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050 or by submitting a written complaint to:

Grievances and Appeals Unit
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903-2699

Acknowledgment and Completion Timeframes

Within 10 business days of receipt of a complaint, the GAU will mail or phone acknowledgment of the complaint, indicating that every effort will be made to resolve the issue within, in most cases, 30 business days.

Review

The complaint is assigned to a Case Specialist who is responsible to research all pertinent information and provide a response to the complaint. The physician/provider is then informed of the outcome in writing.

In most cases, there is one level of review for a complaint. However, in certain circumstances where there is the potential for a different outcome, a second level may be

offered. If the complaint is eligible for a second level of review, the determination letter will indicate this option. A physician/provider who is dissatisfied with BCBSRI's determination may pursue the issue through a court of law.

Provider Administrative Appeal Process

An administrative appeal is an oral or written request from the provider, to BCBSRI, to reconsider a full or partial administrative denial. Providers must submit their administrative appeals within 60 days of the initial notice of a denied claim or incident date.

Appeals may be filed with BCBSRI by contacting the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050 or by submitting a written appeal to the address indicated in the **Provider Complaint Process** section above.

Acknowledgment and Completion Timeframes

Within 10 business days of receipt of an administrative appeal, the GAU will mail or phone acknowledgment of the appeal, indicating that every effort will be made to resolve the issue within, in most cases, 60 calendar days.

Review

The appeal is assigned to a Case Specialist who is responsible to research all pertinent information and render a decision on the appeal. The physician/provider is then informed of the decision in writing.

There is one level of administrative appeal. A physician/provider who is dissatisfied with BCBSRI's determination may pursue the issue through a court of law.

Credentialing and Recredentialing

A standard formalized credentialing and recredentialing process ensures that BCBSRI members have access to physicians/providers who are known to be qualified and committed to network goals and objectives.

Requirements

Only those physicians/providers who meet BCBSRI's credentialing/recredentialing requirements are eligible to participate in the network. As a participating physician/provider, or a physician/provider applying for participation, you are required to supply us with the information needed to review and verify your credentials. In addition to completing a comprehensive application, all physicians/providers must supply evidence of the following:

- Residency, formal training, and work history for the preceding five years (initial applicants only).

- Board certification, if indicated on the application, or documentation that certification has been renewed after expiration or recently acquired, as applicable.
 - Current unrestricted medical/professional license in state where practicing and acceptable licensure history.
 - Current Unrestricted Federal Drug Enforcement Agency (DEA) certificate when applicable to the individual specialty or physician/provider type. A separate DEA registration must be provided for each state in which the physician/provider practices.
 - Status in good standing and active admitting privileges with a contracted BCBSRI hospital. (This requirement may be waived if physician/provider is in a specialty practice that does not admit patients, such as anesthesiology, or if the physician's/provider's patients are admitted by another physician/provider already participating with BCBSRI.)
 - Proof of adequate professional liability insurance and acceptable history of malpractice claims experience.
 - Compliance with office site and medical record review record requirements.
- Applies to:
- Personal physicians at initial credentialing
 - All OB/GYNs at time of initial credentialing
 - High-volume specialists at time of initial credentialing and selected high-volume specialists at recredentialing

As part of the credentialing process, all eligible practitioners are required to supply their National Provider Identifier (NPI). The following information provides background on the NPI requirement, as well as how to obtain one and send it to us.

Background on the NPI Requirement

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique identifier for all healthcare providers. The National Provider Identifier (NPI) Final Rule issued January 23, 2004 adopted the NPI as that standard. The NPI is a 10-digit, numeric identifier.

You will need either an Individual NPI, "Entity Type 1"; an Organizational NPI, "Entity Type 2"; or, if you have individual physicians/practitioners who are working for a taxable entity, both Types 1 and 2.

The Federal Register defines Types 1 and 2 as follows:

- Type 1 – issued to individual healthcare providers
- Type 2 – issued to healthcare organizations

For example, individual doctors would use Type 1 while a group practice would use Type 2.

How to Obtain Your NPI

You may request your NPI via the following methods:

By phone: 1-800-465-3203 (NPI Toll Free) 1-800-692-2326 (NPI TTY)

By email: customerservice@npinenumerator.com

On the Web: <https://nppes.cms.hhs.gov>

By mail: NPI Enumerator, PO Box 6059, Fargo, ND 58108-6059

Please send your NPI directly to BCBSRI. Once you receive your NPI(s), please fax the confirmation letter/email you received from the National Plan and Provider Enumeration System along with your name and BCBSRI Provider ID to (401) 459-1774.

Physician/Provider Right to Review Information

Physicians/providers have the right to review information we obtain to evaluate their credentialing application and to contact us to be informed of the status of the application. Physicians/providers may contact the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050 to inquire about the status of an application.

Physicians/providers have the right to review information obtained from any outside primary sources (e.g., malpractice insurance carriers, state licensing boards, etc.). This policy does not require us to allow providers to review references, recommendations, or other information that is peer-review protected.

In addition, BCBSRI will notify you if credentialing information obtained from other sources varies from the information provided on the application. You may be notified by mail, fax, telephone, or email. BCBSRI is not required to reveal the source of information if it is not obtained to meet credentialing verification requirements or if disclosure is prohibited by law. Lastly, physicians/providers have the right to correct erroneous information submitted by another source by sending a written explanation of the discrepancy to the credentialing specialist or by calling the Physician and Provider Service Center as indicated above. The corrected information must be received within 14 calendar days. The corrected information and recorded date of receipt will be presented at the next applicable Credentials Committee for review. Reminders of these rights will periodically appear in physician/provider publications.

Physician/Provider Office and Medical Record Review

BCBSRI conducts pre-contractual reviews of office sites and medical records for personal physicians, OB/GYNs, and selected high-volume specialists when they apply for network participation. They may also be performed as part of ongoing monitoring, relocations, addition of offices, the recredentialing process (selected high-volume specialists only), or when performance issues are identified through other means. These on-site reviews assess compliance with all applicable NCQA, regulatory, and BCBSRI participation standards,

and promote improvements in record-keeping and office management practices, as well as overall member access. Our Quality Management Department contacts each provider to schedule the review and sends a reminder letter and copy of the guidelines we use.

After the site review, the physician/provider receives a summary of the findings and a copy of the completed review evaluation tool. The summary will include any needed corrective actions and time frames for completing them, as applicable. In some instances, identified deficiencies may be corrected by submitting required documentation. In other cases, we may require follow-up site visits or medical record review audits to confirm that all corrective actions have been taken. Those specific actions will be documented in the summary letter.

The results of these reviews are incorporated into the credentialing, recredentialing, and quality management processes and are presented with the provider's application to the Credentials Committee.

Initial Application Process

Physicians/providers may contact the Physician and Provider Service Center to obtain a Request for Provider Participation/Application form. For your convenience, this form is also included in the Appendix. You can also obtain forms in the Provider section of BCBSRI.com. Once this form is received, BCBSRI will start the application process by contacting the Council for Affordable Quality Healthcare (CAQH) and requesting that a CAQH registration kit be mailed to the physician/provider. Effective January 1, 2007, BCBSRI agreed to participate in a joint initiative facilitated by the Office of the Health Insurance Commissioner (OHIC) and as a result, the CAQH Universal Credentialing Data Source is now our primary credentialing and recredentialing application. CAQH introduced this secure online application database to streamline the process and eliminate the need for practitioners to fill out and submit multiple paper applications for participating health plans. All participating practitioners must register and maintain an active status with the CAQH credentialing application database, if not registered already. The online application replaces the need for paper credentialing and recredentialing applications. As always, it is very important that you submit a completed application within the specified timeframes. As a general rule, it is best to submit new applications at least two to three months prior to a new physician/provider's commencement of employment. Once completed, the CAQH system requires that you review, update, and re-attest to the validity of your information every 120 days. If we are missing any information or materials, we will send you a letter requesting it as soon as possible.

Recredentialing Process

About four months prior to a physician's/provider's scheduled recredentialing date, we start the recredentialing process by checking the CAQH Universal Credentialing Data

Source to verify that the physician/provider has an active, completed online application. If the application is updated and all required documents are attached, BCBSRI will access the information and process the application. If the physician/provider is not active with CAQH, we will notify them that they are due for recredentialing and that they must register with CAQH and complete the online application. It is important for the physician/provider to make sure that their application is current and has been re-attested to within the last 120 days as required by CAQH.

After we receive and verify these credentials and data, the physician's/provider's credentialing file is presented to the Credentials Committee for approval/denial of continued network participation.

Physician/Provider Notification

Approved providers are notified by mail. First-time physician/provider applicants, who have been approved, are instructed that they can call the Physician and Provider Service Center to arrange for an office orientation with a Provider Relations Representative. Occasionally, the committee recommends that a physician's/provider's application be approved, contingent on certain requirements being met. If so, the physician's/provider's notification letter will outline these requirements and the timeframe for meeting them. BCBSRI will help with training, clarification of the needed actions, and/or developing action steps, as applicable. The physician/provider will not be considered participating and may not provide care to our members until all conditions are met.

The committee sends a certified letter of notification to any physician/provider who has been denied initial or continued participation. The letter will outline the reasons for the denial or termination, and explain how the physician/provider may appeal the decision if he/she wishes.

Procedures

Recredentialing/Credentialing

- When you receive your CAQH registration kit, please submit the online application with all items completed at least two to three months before the physician/provider is scheduled to start working. This will ensure that the physician/provider can begin treating patients upon their hire date.
- When you are due for recredentialing, BCBSRI will verify with CAQH that you have an active application on file. If you are registered with CAQH and all required credentialing documents are current, we will access the information and process the application. You will be notified by BCBSRI if you are not active with CAQH or if you have missing or outdated documents. NCQA and CMS impose strict time frames for the recredentialing process. We are required to recredential you every 36

months. Your timely response upon receiving notification helps us avoid unnecessary delays and possible termination. It is also important that you maintain your CAQH application with updated and validated information so that BCBSRI can access your online application and complete the recredentialing process.

- **File an appeal if you disagree with the Credentials Committee’s decision.** BCBSRI strives to provide our members a network of qualified providers, and will make every reasonable effort to help providers comply with our participation standards. Occasionally, if a provider cannot demonstrate the necessary capabilities or qualifications, we must terminate his/her contract. Our extensive appeals process is available to any physician/provider who would like an adverse decision reconsidered. For information on the appeals process, please see page 44.
- **Promptly implement any specified corrections that may be needed before approval can be granted.** A quality consultant will help you determine how corrections can be made efficiently and quickly, and will help you develop and implement a work plan, if needed.

Site Visits

- **Promptly implement any specified corrections that may be needed before approval can be granted.** A quality consultant will help you determine how corrections can be made efficiently and quickly, and will help you develop and implement a work plan, if needed.

CHAPTER 4

ENROLLMENT AND ELIGIBILITY

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ENROLLMENT AND ELIGIBILITY

Overview of BCBSRI Plans

You and your office staff are required to be familiar with all of the BCBSRI health plans, their enrollment objectives, and the populations to which they are marketed.

Understanding the enrollment and eligibility provisions and requirements of BCBSRI health plans helps office staff create a secondary support system to ensure the timely and efficient delivery of both clinical and administrative services.

The extent of your participation in the BCBSRI network is defined by the range of health plans available to members.

Our commercial plans are marketed to employer groups, and our individual plans are marketed to individuals and families who are not eligible for employer or government-sponsored health insurance. The majority of plans can be purchased directly through BCBSRI or through HealthSource RI (HSRI), Rhode Island's health insurance exchange. We offer the following products:

Commercial (Employer Market)	Individual Market (Direct Pay)
BlueSolutions for HSA	BlueSolutions for HSA Direct
BlueSolutions SelectRI	VantageBlue Direct
VantageBlue	VantageBlue Select RI Direct
VantageBlue SelectRI	BasicBlue Direct
HealthMate Coast-to-Coast	See Chapter 7 for Product Descriptions
LifeStyleBlue	
BlueCHiP	
BlueCHiP for Healthy Options → available through HSRI only	
Classic Blue	

- BasicBlue Direct – Preferred provider organization plan that offers nationwide coverage (Available to individuals under age 30 or those who qualify for a hardship exemption)
- BlueCHiP – Coordinated care plans
- BlueCHiP for Healthy Options – HEALTHpact plan available only through HealthSource RI
- BlueSolutions for HSA – Consumer-driven/HSA-qualifying health plan

- BlueSolutions for HSA Direct – Consumer-driven/HSA-qualifying health plan in Direct Pay market
- BlueSolutions SelectRI – Consumer-driven/HSA-qualifying health plan with network option in the Large Group market
- Classic Blue – Preferred provider organization plan that offers nationwide coverage (offered to municipality groups only)
- HealthMate Coast-to-Coast – Preferred provider organization plan that offers nationwide coverage
- LifeStyleBlue – 3-in-1 health plans based on lifestyle and healthcare needs
- VantageBlue – Value-based benefit plans
- VantageBlue Direct – Value-based benefit plans in the Direct Pay market
- VantageBlue SelectRI – Preferred provider organization plan that offers a local network option and nationwide coverage
- VantageBlue SelectRI Direct – Preferred provider organization plan that offers a local network option and nationwide coverage in the Direct Pay market

BlueCHiP for Medicare is BCBSRI's Medicare Advantage plan. BlueCHiP for Medicare is a coordinated care plan offered by BCBSRI, which contracts with the Centers for Medicare & Medicaid Services (CMS) on an annual basis. BlueCHiP for Medicare offers additional benefits above those provided under Original Medicare, such as Part D prescription drug coverage (on certain plans) and worldwide emergency coverage. To be eligible to enroll in BlueCHiP for Medicare, individuals must be enrolled in Medicare Parts A & B, and must permanently reside in Rhode Island. (BlueCHiP for Medicare retiree group members can reside in licensed service areas in Bristol County, Massachusetts and certain ZIP codes in New London County, Connecticut.) Generally, enrollees cannot be diagnosed with end-stage renal disease (ESRD) prior to enrollment. Enrollees must also agree to obtain their medical care through plan providers, except:

- In an emergency,
- If urgent care is needed,
- If the service is pre-approved by the plan or a plan-contracted partner, or
- If it is covered under the point-of-service benefit available on certain plans.

Benefit plans must meet federal regulatory requirements outlined in the CMS Medicare Managed Care manual. Enrollees who leave the service area for more than six months in a row are no longer eligible to continue their enrollment.

Plan 65 is BCBSRI's Medicare supplement product. For more than 30 years, BCBSRI has been offering Plan 65, which provides coverage for some or all of the deductibles and copayments for which a Medicare beneficiary would normally pay under the Original

Medicare program. To be eligible to enroll, individuals must be enrolled in Medicare Parts A & B and live in Rhode Island.

BCBSRI offers the Age-In Credit Program, which is available to new retirees who join one of our individual Plan 65 plans within six months of enrolling in Medicare Part B. The Age-In Credit Program offers a 30 percent discount on the plan's regular rate for the first year a member is enrolled, a 20 percent discount in the second year, and a 10 percent discount in the third year. After the third year, the regular rate for the plan option applies.

Members in Plan 65 Select plans must use the Select hospital network for elective inpatient services to avoid cost-sharing. However, emergency inpatient services are covered by Plan 65 Select, regardless of whether or not the hospital participates in the Select network.

New England Health Plans (NEHP) is a regional plan set up to administer both point-of-service and HMO products throughout New England.

IMPORTANT NOTE: While some benefits and terms of services described on the following pages apply to all BCBSRI plans, others are specific only to BlueCHiP plans. This chapter provides an overview of the different plans and where applicable, and also calls your attention to some of the details you and your staff should know that relate specifically to the various BlueCHiP plans.

Member ID Cards (also referred to as Plan Membership Cards)

Every BCBSRI member receives an enrollment identification card/plan membership card in his or her name, which contains the following information:

- Member name
- Member ID number
- Important BCBSRI phone numbers
- Product name, such as HealthMate Coast-to-Coast, BlueCHiP, or BlueCHiP for Medicare
- Copayments and/or deductible information (on some cards)
- Prescription drug coverage information

For Medicare Advantage plans (e.g., BlueCHiP for Medicare), Medicare Organizations are also required to include the plan type after the plan name in all documents/materials in which the plan name is referenced. This includes plan membership cards. Examples include “BlueCHiP for Medicare Plus (HMO)” and “BlueCHiP for Medicare Preferred (HMO-POS).” In the second example, the plan type indicates that the Preferred plan has a point-of-service benefit.

Procedures

BCBSRI physician/provider offices are required to confirm each member's health plan, basic enrollment data, and key benefit information from the member's ID card. These procedures help protect you as well:

- Ask to see a member's ID card at every visit, to verify eligibility and confirm benefit information.
- If you are the PCP for a member enrolled in one of our BlueCHiP plans, compare the member's information against your monthly enrollment report.
- If uncertain about a member's eligibility, call BlueLine, our interactive information line. Or log onto the provider section of BCBSRI.com and click on Patient Profile located on the left navigation screen. You must have a user name and password to access the provider section.
- If preauthorization is recommended for treatment, call Utilization Management for preauthorization. Or log onto the provider section of BCBSRI.com to submit a preauthorization request online for the following services:
 - Durable medical equipment
 - Inpatient admission (Birth/Delivery)
 - Inpatient admission request (Emergency/Elective)
 - Select outpatient services and out of network
 - Private duty nursing
- If you are a specialist rendering a service to a member covered by a BlueCHiP plan, ensure the referral received is from his/her PCP. Please note that referrals are not required for BlueCHiP for Medicare members.
- If you are a specialist and a member of a BlueCHiP plan is self-referring or you are a PCP but you are not the member's PCP, inform the member prior to services being rendered that he/she may be liable for some or all of the cost of the service. Document this discussion in the member's file or have the member sign a self-referral acknowledgement form. We may audit files to confirm acknowledgement.

Eligibility for All Plans

The office staffs of personal physicians are required to verify member eligibility for coverage with each date of service, and to maintain accurate health plan information for each member who receives care through that site. We do not compensate physicians for services rendered to ineligible members.

Office staffs play a critical role in members' satisfaction with the clinical and administrative care and service they receive. Staff members are both ombudsmen for the member and a BCBSRI liaison for the physician.

A physician's/provider's office staff must know which plan the member is enrolled in. (For BlueCHiP plan members, the designated PCP must be able to interpret basic enrollment data, and understand other membership-related information.)

Verification of eligibility begins at the physician's/provider's office, but BCBSRI fully supports the process, helping physicians avoid providing services to ineligible members.

IMPORTANT NOTE: Eligibility verification reflects the member's status at the time of inquiry. It may not reflect the member's eligibility at the time these services are actually provided. Therefore, it is important to verify eligibility on the date the service is performed. If a group retroactively terminates, eligibility can be affected.

Unlisted Members/Members Without ID Cards

If a patient requesting an appointment does not have a BCBSRI ID card, check patient eligibility via BlueLine or on the website prior to rendering the service. If eligibility cannot be confirmed, you will be advised to tell the member to call their employer's benefit administrator. You will not be compensated for services rendered to a member whose eligibility has not been verified.

If multiple appointments are needed within the same month, be sure that verification applies for all anticipated visits.

For BlueCHiP Plan Members: All members new to a PCP's practice who request an appointment must be offered an appointment within 30 days. Compliance with this requirement is monitored by BCBSRI during the recredentialing process.

IMPORTANT NOTE: For all patients, we recommend keeping a log of all eligibility verifications obtained through BCBSRI.

PCP Selections for BlueCHiP and BlueCHiP for Healthy Options Plan Members

BlueCHiP plan members are required to have an assigned PCP. (Note that for all other BCBSRI plans, this is not the case; members of other plans are not required to have a PCP.)

IMPORTANT NOTE: If a member has serious complaints about the quality of care or service being received from a PCP, or if the physician believes that the member's behavior has caused a significant breakdown in the physician-patient relationship, BCBSRI may assist the member in selecting another PCP. In the meantime, Medical Management will authorize another PCP to provide any needed services.

Selection/Assignment Effective Dates for All Plans

BCBSRI Plans – Coverage for these members is always effective on the first of the month.

BlueCHiP for Medicare – Effective dates are as follows, according to CMS guidelines:

- *Initial Coverage Election Period (ICEP) for New Medicare Beneficiaries*
The ICEP is the period during which an individual newly eligible for Medicare may make an initial election to enroll in a Medicare Advantage (MA) plan. This period begins three months immediately before the individual's first entitlement to **both** Medicare Part A and Part B and ends on the later of:
 1. The last day of the month preceding entitlement to both Part A and Part B, or;
 2. The last day of the individual's Part B initial enrollment period.

The initial enrollment period for Part B is the seven-month period that begins three months before the month an individual meets the eligibility requirements for Part B, and ends three months after the month of eligibility.

Note: Once an ICEP election is made and enrollment takes effect, the ICEP election has been used.

- *Annual Enrollment Period (AEP)*
The annual enrollment period is from October 15 through December 7, with a January 1st effective date. During the AEP, Medicare Advantage-eligible individuals may enroll in or disenroll from BCBSRI. The last election made, determined by the application date, will be the election that takes effect.
- *Medicare Advantage Disenrollment Period*
The Medicare Advantage Disenrollment Period is from January 1 to February 14. During this time, beneficiaries will be able to disenroll and return to Fee-for-Service (Original Medicare) with or without a separate Part D prescription drug plan (PDP).
- In addition, under limited circumstances and specifically outlined by CMS, a Medicare beneficiary may be able to make an election under an SEP.

Effective Dates for Newborns

Newborns are covered as of their date of birth, but the enrollment process must be finalized in order for coverage to remain in force.

Commercial plans – These members are required to notify BCBSRI within 31 days of the birth of a newborn who is to be permanently added to their membership.

If the member has an individual or two-person contract, the newborn's coverage will be effective on the first of the following month after the birth.

If you are aware that a dependent child delivers a baby, you may consider the newborn covered for 31 days following the birth date even if the newborn does not appear on your monthly eligibility report. An exception would be a grandchild, where the dependent is covered but the grandchild would not be.

Contact the Physician and Provider Service Center if you have any uncertainties regarding a child's eligibility for continuing services.

Retroactive Effective Dates

To reflect an enrollment transaction in any given monthly report, information must be received by the 20th of the preceding month. If information is not received by then, the enrollment will usually appear on the report for the second month following the effective date, and a retroactive effective date will be indicated.

BlueCHiP for Medicare – For an individual enrollment, in general, there is no retroactive effective date determined by CMS. For group enrollments, there is a 90-day limitation for retroactive effective dates (based on CMS authorization).

CHAPTER 5

MEMBER RIGHTS AND RESPONSIBILITIES

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MEMBER RIGHTS AND RESPONSIBILITIES

Member Issues

In recent years, the world of healthcare has become increasingly complex. BCBSRI is committed to guiding our members toward the care and services they need as smoothly and easily as possible.

Upon enrollment, our members are granted certain rights and protection of these rights in all their encounters with BCBSRI's representatives, including physicians and other network providers, providers' employees, BCBSRI employees, and anyone else who has a role in the delivery of care and service. We expect all of our representatives to observe the principles we've established to preserve these rights.

In exchange for this careful observance of their rights, members guarantee to assume responsibility for their attitude, knowledge, and behavior related to the healthcare services they receive while enrolled.

BCBSRI Commercial and HealthSource RI Plans: Member Rights and Responsibilities

The following are the member rights and responsibilities for our BCBSRI Commercial and HealthSource RI plans, **as they are communicated to our members.**

As a BCBSRI member, you have the right to:

- Receive information about BCBSRI, our services, our practitioners and providers, and your member rights and responsibilities.
- Be treated with respect and with recognition of your dignity and right to privacy.
- Receive a second opinion at the applicable copayment, coinsurance, and/or deductible concerning a proposed surgical procedure.
- Participate with practitioners in making decisions about your healthcare. This includes receiving information concerning your diagnosis, treatment, and prognosis in terms that can be reasonably understood. In the event your doctor considers access to such information inadvisable by reason of medical condition, age, and/or lack of decision-making capacity, the information will be given to an appropriate person on your behalf.
- Have a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.

- Know about resources such as Customer Service representatives, complaints and appeals processes, and language interpretation resources that can help you answer questions and resolve problems and complaints.
- Voice complaints or file appeals about BCBSRI or the medical care you receive.
- Make recommendations regarding BCBSRI's rights and responsibilities policies for members.
- Receive impartial (fair) access to treatment. This means that you have the right to all medically indicated treatment that is a covered benefit, regardless of your race, religion, sex, sexual orientation, national origin, cultural background, disability, or financial status.
- Receive medical care and services provided by health professionals who meet the professional standards established by BCBSRI.
- Select a PCP.

As a BCBSRI member, you have the responsibility to:

- Fulfill financial obligations. You are responsible for paying applicable premiums, deductibles, copayments, coinsurance, and other fees as outlined in your plan documents.
- Know the extent and limitations of your healthcare benefits, as contained in your subscriber agreement/benefit booklet.
- Understand your health problems and participate in developing mutually agreed upon treatment goals. This includes certain circumstances in which your doctor may recommend a course of treatment that is not covered by your plan. Ask your doctor to clearly explain your treatment plan and what is expected of you until you fully understand.
- Schedule regular preventive care appointments with your PCP. This includes routine physical exams, health screenings, and immunizations.
- Give accurate and complete information (to the extent possible) about your present and past medical condition that BCBSRI and your healthcare provider need in order to provide for care. You should report unexpected changes in your condition to your healthcare provider.
- Follow the treatment plan and instructions for care that you have agreed to with your healthcare provider. If you feel that you cannot follow through with your treatment, tell your healthcare provider.
- Present your member ID card whenever you seek care and use the card only as appropriate. Make sure that other people do not use your member ID card.

- Keep appointments. Know your provider's appointment cancellation policy, and promptly cancel any appointment that you do not need or cannot keep.
- Be considerate of healthcare professionals, staff, and other patients.
- Seek care through your PCP whenever possible (except in emergencies).

BlueCHiP Coordinated Health Plans: Member Rights and Responsibilities

The following are the member rights and responsibilities for our BlueCHiP Coordinated Health Plans, **as they are communicated to our members.**

As a BlueCHiP Coordinated Health Plan member, you have the right to:

- Receive information about BCBSRI, our services, our practitioners and providers, and your member rights and responsibilities.
- Receive medical care and services provided by a network of physicians.
- Receive medical care and services provided by health professionals who meet the professional standard established by BCBSRI.
- Select and change a primary care physician (PCP).
- Be referred by your PCP to the service of a specialist or healthcare professional as necessary.
- Receive the medical information you need to participate in your healthcare. This includes information concerning your diagnosis, treatment, and prognosis in terms that can be reasonably understood. In the event your physician considers access to such information inadvisable by reason of medical condition, age and/or lack of decision-making capacity, the information will be given to an appropriate person on your behalf.
- Know about resources such as Customer Service representatives, grievance and appeals processes, and language interpretation resources that can help you answer questions and resolve problems and complaints.
- Be treated with respect and recognition of your dignity and right to privacy.
- Receive impartial access to treatment. You have the right to all medically indicated treatment that is a covered benefit, regardless of your race, religion, sex, sexual orientation, national origin, cultural background, disability, or financial status.
- Receive a second opinion concerning a proposed surgical procedure, at the applicable copayment.
- Make recommendations regarding BCBSRI's members' rights and responsibilities policies.

As a BlueCHiP Coordinated Health Plan member, you have the responsibility to:

- Know the extent and limitations of your healthcare benefits, as contained in your subscriber agreement/Evidence of Coverage.
- If required under your plan, make certain all services are authorized by your PCP and are received from participating providers unless specific plan authorization is otherwise obtained.
- If required under your plan, seek care through your PCP (except in emergencies).
- Recognize the effect of your lifestyle on your health. Your health depends not just on care provided by plan providers, but also on the decisions you make in your daily life, such as smoking or ignoring provider recommendations.
- Schedule regular preventive care appointments with your PCP. This includes routine physical exams, health screenings, and immunizations.
- Present your membership card only as appropriate. Make sure that other people do not use your ID card.
- Understand your health problems and participate in decisions concerning a proposed treatment plan. This includes certain circumstances in which your physician may recommend a course of treatment that is not covered by your plan.
- Ask your physician to explain clearly your treatment plan and what is expected of you until you fully understand.
- Follow the treatment plan you and your healthcare provider agree on. If you feel as though you cannot follow through with your treatment, tell your healthcare provider.
- Keep appointments. Know your provider's appointment cancellation policy and promptly cancel any appointment that you do not need or cannot keep.
- Provide accurate and complete information about your present and past medical condition, as you understand it. You should report unexpected changes in your condition to your healthcare provider.
- Be considerate of healthcare professionals, staff, and other patients.
- Fulfill financial obligations. You are responsible for paying applicable premiums, copayments, and other fees as outlined in your plan documents.

BlueCHiP for Medicare Plans: Member Rights and Responsibilities

The following are the BlueCHiP for Medicare member rights and responsibilities, **as they are communicated to our members.**

Please note that the BlueCHiP for Medicare Core plan does not include Part D prescription drug coverage. Therefore, all references below to prescription drugs and network pharmacies are not relevant to members of this plan.

We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or Spanish).

To get information from us in a way that works for you, please call Customer Service.

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

We must treat you with fairness and respect at all times.

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

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

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. Call Customer Service to learn which doctors are accepting new patients. We do not require you to get referrals to go to network providers.

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

We must protect the privacy of your personal health information.

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

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

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

How do we protect the privacy of your health information?

We make sure that unauthorized people don't see or change your records.

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to

do this, we will work with your healthcare provider to decide whether the changes should be made.

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

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

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

As a member of BlueCHiP for Medicare, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service:

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the *BlueCHiP for Medicare Provider Directory*.
 - For a list of the pharmacies in the plan's network, see the *BlueCHiP for Medicare Pharmacy Directory*.
 - For detailed information about our providers or pharmacies, you can call Customer Service or visit our website at www.BCBSRI.com/medicare.
- **Information about your coverage and rules you must follow in using your coverage.**
- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written

explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.

- If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Rhode Island Department of Health, Cannon Building, 3 Capitol Hill, Providence, RI 02908.

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

You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we are required to treat you fairly.**

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

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

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

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call Customer Service.**
- You can **call the State Health Insurance Assistance Program.**
Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How to get more information about your rights

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

- You can **call Customer Service.**
- You can **call the State Health Insurance Assistance Program.**
- You can contact **Medicare.**

- You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: <http://www.medicare.gov/Pubs/pdf/11534.pdf>.)
- Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

What are your responsibilities?

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.**
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know.
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you with it.
- **Tell your doctor and other healthcare providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other healthcare providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must pay your plan premiums to continue being a member of our plan.
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost).
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
 - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service.
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.

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

Standards of Care and Service

The healthcare services delivered to BCBSRI members should conform to the same standards for care and service that you would offer to any other patient. Physicians/providers who observe the principles of professional ethics and appropriate medical care are the foundation of our commitment to ensuring that members receive the best care and services available.

Responsibility for Treatment

BCBSRI members have the right to receive treatment or services. You may not refuse to treat a member strictly because the services are not covered by the member's health plan.

You are not restricted in any way from discussing treatment alternatives with BCBSRI members, regardless of whether those alternatives agree with BCBSRI coverage or administrative or medical policies.

BCBSRI's utilization management procedures are used solely to establish whether services are eligible for coverage under an enrolled member's health plan benefits, based on objective guidelines adopted by BCBSRI and used to determine medical necessity and appropriateness of the services. The decision to proceed with treatment rests with you and/or the member.

Non-Discrimination

You may not discriminate in the treatment of BCBSRI members or in the quality of services provided to them on the basis of race, sex, age, ethnicity, genetic information, sexual orientation, cultural or educational background, economic status, English proficiency, reading skills, physical or mental ability, religion, handicap, national origin, place of residence, health status, or source of payment.

Practice limitations for enrollment or treatment of a demographic segment of the BCBSRI population (such as pediatric or geriatric patients) must be consistent with the similar limitations affecting your non-BCBSRI patients.

Advance Directives

You may not refuse to treat or otherwise discriminate against a member strictly because he or she has authored a durable power of attorney for healthcare, a declaration under the Natural Death Act, or any other recognized advance directive.

BCBSRI recognizes the right of any adult member to complete a durable power of attorney for healthcare, a declaration under the Natural Death Act, or any other recognized advance directive, and expects its participating physicians/providers to honor them, guiding and assisting their patients in these sensitive matters. We do not condition the provision of care or otherwise discriminate against an individual based on whether or not he/she has executed an advance directive.

BCBSRI supplies members with appropriate advance directive forms when they first enroll. They also are available upon request from Customer Service.

Supervision of Office Personnel

You are required to provide appropriate supervision of non-physician practitioners and others who provide information or medical care to your BCBSRI patients. Physicians' offices are required to have guidelines for supervision of non-physician clinical and non-clinical staff. A review of these guidelines is part of the recredentialing process.

Member Complaints and Appeals – General Overview

BCBSRI members are guaranteed an equitable process for reviewing their complaints and appeals. This process is guided by specific rules and regulations that pertain to each of our products and is managed by the BCBSRI Grievances and Appeals Units (GAU).

The procedures established to address and resolve members' complaints and appeals may require your participation as either the resolution point, entry point, or the provider of key information for BCBSRI's formal complaint and appeals process.

Members may submit complaints and appeals in writing (see below for contact information for BlueCHiP for Medicare members) to:

Blue Cross & Blue Shield of Rhode Island
Grievances and Appeals Unit
500 Exchange Street
Providence, RI 02903

Or

Blue Cross & Blue Shield of Rhode Island
Grievances and Appeals Unit: BlueCHiP for Medicare
500 Exchange Street
Providence, RI 02903

Or they may be submitted by fax to:

- (401) 459-5668 (Plan 65 and BlueCHiP for Medicare)
- (401) 459-5005 (all other lines of business)

Member Complaints

The member has the option of expressing any kind of dissatisfaction directly to BCBSRI. In many instances, however, he or she may wish to discuss the problem first with you or your staff.

As a BCBSRI physician/provider, you are required to attempt a resolution of a complaint brought directly to your attention when the issue is related to the care and/or service provided by you or your staff.

These types of complaints may include:

- A delay in getting an appointment or prolonged office wait time to see the physician
- Dissatisfaction with medical care received
- Dissatisfaction with billing practices
- Dissatisfaction with office staff

Complaints that can be resolved by your office are usually expressed verbally, although you may ask the member to put the complaint in writing for your office records. Verbal or written complaints presented directly to you and resolved between you and the member do not need to involve BCBSRI, unless you or the member requests our assistance.

If the complaint cannot be resolved between you and the member to the member's complete satisfaction, or it relates to issues beyond your control, you or your staff should direct the member to BCBSRI. See the section titled **Member Complaint Process** for information on how to file a complaint.

Other complaints that should be directed to BCBSRI include:

- Dissatisfaction with BCBSRI's products, services, or staff
- Quality of care issues, such as problems accessing care, poor outcome of care, physician/provider behavior and demeanor
- Provider relationship issues
- Involuntary disenrollment for cause
- Network requirements, provider bills, services excluded from the member's benefit plan, enrollment effective dates, claims payments and payment delays, ID cards, and membership changes

Customer Service manages all general member inquiries about benefits and coverage and will make every effort to resolve verbal complaints at the time of the call.

Member Complaint Process

The following is the administrative complaint process for all products, including BlueCHiP for Medicare. ***Important note: Quality of care complaints are handled by the Quality Management Department and are subject to different guidelines and timeframes.***

When a member contacts Customer Service to initiate a complaint or files a complaint in writing, he or she must provide the following information:

- Name, address, and member ID number
- Summary of the complaint
- Any previous contact with BCBSRI
- A brief description of the relief or solution the member is seeking
- Any additional information such as referral forms, claims, or any other documentation that the member would like us to review
- The date of incident or service

Submission Requirements

Members may file complaints verbally or in writing. Verbal complaints can be filed by contacting our Customer Service Department at the telephone number on the back of the ID card. If the provider is filing the verbal complaint on behalf of the member, they should contact the Physician and Provider Service Center. Written complaints should be directed to the GAU at the address or applicable fax number indicated at the beginning of this section. *Please note that BlueCHiP for Medicare complaints must be submitted within 60 days of the occurrence or event that precipitated the complaint.*

Acknowledgment

The GAU will mail or phone acknowledgment of the complaint within ten (10) business days of receipt of a written or verbal complaint.

Level 1 Complaint

The GAU will conduct a thorough review and send a written response to the member within thirty (30) business or calendar days, depending on product. The determination letter will provide the member with the rationale for our decision/response as well as providing information on the next steps if the member is not satisfied with the outcome.

Level 2 Complaint

This process is available only when the member has been offered a second level of complaint in the Level 1 determination letter. Please note that BlueCHiP for Medicare members do not have a limit on the levels of complaint they may file.

The GAU will conduct a thorough review of the complaint and send a written response to the member within thirty (30) business or calendar days, depending on product. The determination letter will provide the member with the rationale for our decision/response as well as providing information on the next steps if the member is not satisfied with the outcome.

Member Administrative Appeals

An administrative appeal is an oral or written request for the Plan to reconsider a full or partial administrative denial. Examples of administrative appeals include:

- Request to waive deductible/coinsurance/copayment or disputing the calculation of the deductible/coinsurance/copayment
- Request for full coverage to an out-of-network provider for convenience purposes or if not referred by a participating primary care provider (PCP)
- Request for payment of a service that is not a covered benefit
- Request for review of an outcome of a complaint investigation where member is not satisfied with the outcome of the investigation.

If BCBSRI denies payment for a service, the member will receive an explanation of benefits with specific instructions for filing an administrative appeal.

Commercial Products Only – If you are filing an administrative appeal on a member's behalf and the appeal can be filed verbally, you may contact the Physician and Provider Service Center to initiate the appeal.

Member Medical Appeals

A medical appeal is a verbal or written request for us to reconsider a full or partial denial of a prior authorization or a claim for services that we have determined to be:

- Not medically necessary
- Cosmetic

If BCBSRI denies payment for a service for medical reasons, the member will receive the denial in writing. The written denial will explain the reason for the denial and provide specific instructions for filing a medical appeal.

Commercial Member Administrative Appeal Process

The following is the administrative appeal process for all products except BlueCHiP for Medicare, which will follow.

The appeal must include the following information:

- Name, address, and member ID number
- Summary of the administrative appeal

- Any previous contact with BCBSRI
- A brief description of the relief or solution the member is seeking
- Any additional information such as referral forms, claims, or any other documentation that the member would like us to review
- The date of service

Submission Time Frame and Requirements:

Appeals must be filed within 180 calendar days from the date of the denial notification for all products except BlueCHiP for Medicare, which is outlined below.

A member or his/her designee may file an appeal verbally or in writing for all products except BlueCHiP for Medicare, which is outlined below.

Verbal appeals can be filed by the member by contacting our Customer Service Department at the telephone number on the back of the ID card.

Acknowledgment

The GAU will mail or phone acknowledgment of the appeal within ten (10) business days of receipt of a written or verbal appeal.

Level 1 Review

The GAU will conduct a thorough review of the appeal and send a written response to the member within thirty (30) to sixty (60) calendar days, depending on product. The determination letter will provide the member with our decision to approve or deny the appeal, the rationale for our decision and information on the next steps if the member is not satisfied with the outcome.

Commercial Member Medical Appeal Process

The following is the medical appeal process for all products except BlueCHiP for Medicare, which will follow.

The appeal must include the following information:

- Name, address, and member ID number
- Summary of the medical appeal
- Any previous contact with BCBSRI
- A brief description of the relief or solution the member is seeking
- Any additional information such as referral forms, claims, or any other documentation that the member would like us to review
- The date of service

Submission Timeframe and Requirements:

Appeals must be filed within 180 calendar days from the date of the denial notification for all products except BlueCHiP for Medicare, which is outlined below.

A member or his/her designee may file an appeal verbally or in writing for all products except BlueCHiP for Medicare, which is outlined below.

Acknowledgment

The GAU will mail or phone acknowledgment of the appeal within ten (10) business days of receipt of a written or verbal appeal.

Level 1 Review

The GAU will gather all the necessary information for a member's appeal and conduct a review. The member will be notified of our decision within the following timeframes:

- An expedited appeal will be completed within 72 hours of receipt of the appeal if waiting for the standard time frames could seriously jeopardize a person's life or health or their ability to regain maximum function. The member or his/her physician can request an expedited appeal. Please note that BCBSRI may deny a request to conduct an expedited review if the circumstances do not meet the established criteria; the appellant will be notified that the request will be reviewed according to the standard appeal time frame.
- For pre-service or concurrent appeals, the member will receive written notification of the determination as quickly as his/her health requires, but no later than fifteen (15) calendar days of receipt of the appeal.
- For retrospective appeals, the member will receive written notification of the determination within fifteen (15) business days of our receipt of the appeal.

Level 2 Review: Applicable only to members with employer group coverage.

The member may request a Level 2 appeal review if our denial was upheld during the Level 1 appeal process. The Level 2 appeal review will be reviewed by a provider in the same or similar specialty as the treating provider. The response time frames are the same as Level 1.

External Appeal: Available to members with employer group coverage after Level 2 appeal denial. Available to members with individual coverage after the Level 1 appeal denial.

If the member remains dissatisfied with the determination of BCBSRI's internal review (Level 1 and Level 2) process, he/she may request an external review by an external review agency approved by the Rhode Island Department of Health. Details on this process are enclosed with the final adverse determination letter.

For all non-expedited appeals, the external review agency will notify the member of its determination within ten (10) business days of the agency's receipt of the information.

For all expedited appeals, the external appeals agency will notify the member of its determination within two (2) business days, not to exceed seventy-two (72) hours from receipt of the appeal.

Member Appeal Rights

Accessing Information

Upon request, the member may be provided or may appear in person to review, free of charge, reasonable access to copies of all documents, records, and other information relevant to the claim for benefits.

New or Additional Evidence

We must provide the member, free of charge, with any new or additional evidence considered, relied upon, or generated by BCBSRI in connection with the appeal; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is provided to give the member a reasonable opportunity to respond prior to that date.

Part C Member Administrative/Medical Appeal Process – BlueCHiP for Medicare

The following is the appeal process for BlueCHiP for Medicare for Part C appeals. Please note that CMS refers to an appeal as a request for reconsideration.

The appeal must include the following information:

- Name, address, and member ID number
- Summary of the appeal
- Any previous contact with BCBSRI
- A brief description of the solution the member is seeking
- Any additional information such as referral forms, claims, or any other documentation that the member would like us to review
- The date of service
- CMS-1696 Appointment of Representative form (only when the member appoints a personal representative)

Submission Time Frame and Requirements:

Appeals must be filed within 60 calendar days from the date of the denial notification (unless the member has good cause for delay).

Appeals must be filed in writing by the member or an individual the member appoints to represent him/her in the appeal. If the member appoints a personal representative, both the member and the representative must complete and sign a CMS-1696 Appointment of

Representative form. A physician can file a pre-service appeal on behalf of a member without having to be appointed by the member. However, the physician must notify the member that the appeal has been filed.

Acknowledgment

The GAU will mail or phone acknowledgment of the appeal within ten (10) business days of receipt of an appeal.

Level 1 Review

The GAU will conduct a thorough review of the appeal and send a written response to the member within thirty (30) to sixty (60) calendar days. The determination letter will provide the member with our decision to approve or deny the appeal. If the appeal is denied, the determination letter will inform the member that the appeal has been sent to the independent review entity (IRE) for a Level 2 external review.

What is an IRE?

For external appeals, the member's appeal is reviewed by an outside IRE that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to BCBSRI.

Level 2 External Review

The IRE will conduct a new, impartial review of the appeal and send a written response to the member. If they uphold the BCBSRI decision, they will inform the member of his/her rights to appeal further. If they decide in the member's favor, BCBSRI must authorize services or payment within timeframes specified by CMS.

BlueCHiP for Medicare members have additional appeal rights. Members should refer to their Evidence of Coverage for complete details of all levels of external appeals.

Part D Prescription Drug Appeals – BlueCHiP for Medicare

What kinds of decisions can be appealed?

If a member is unhappy with our coverage determination decision, a member can ask for a Part D appeal called a "redetermination." Examples are as follows:

- We did not authorize a Part D drug the member believes he/she is entitled to receive.
- We did not reimburse the member for a Part D drug that he/she paid for.
- We paid less for a Part D drug than the member thinks we should have paid.
- We asked the member to pay a higher copayment amount than he/she thinks he/she is required to pay for a Part D drug.
- We denied an exception request.

How does the appeals process work?

There are five levels in the appeals process. At each level, a request for Part D prescription drug benefits or payment is considered and a decision is made. If the member is unhappy with the decision, he/she may be able to appeal it.

Appeal Level 1:

A member may ask us to review our coverage determination, even if only part of our decision is not what they requested. When we receive the request to review the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination.

Who may file the appeal of the coverage determination?

A member or a prescribing physician, other prescriber, or an appointed representative may file any standard appeal request. In addition, a prescribing physician or other prescriber may request a standard or an expedited redetermination without being the member's representative. However, these are the only appeals that the member's prescribing physician or other prescriber may request on the member's behalf unless he or she is the member's representative. A fast appeal request may be filed by a member, appointed representative, or a doctor. When a physician files a standard appeal on behalf of a member, the physician must notify the member that the appeal has been filed.

How soon must the appeal be filed?

The appeal request must be filed within 60 calendar days from the date the notice of coverage determination was issued. We may grant additional time if the member has a good reason for missing the deadline.

How to file the appeal

1. Asking for a standard appeal

To ask for a standard appeal, a member, physician, or appointed representative can send a written appeal request to the address listed above.

2. Asking for a fast appeal

If the member is appealing a decision we made about giving a Part D drug that has not been received yet, the member or the member's doctor can ask for a fast decision **only** if the member or the member's doctor believes that waiting for a standard decision could seriously harm the member's health or the member's ability to function. (Fast decisions apply only to requests for Part D drugs that the member has not received yet. The member cannot get a fast decision if the member is asking us to pay him/her back for a Part D drug that he/she already received.)

How soon must we decide on your appeal?

1. Standard Decisions:

- We will make a decision within seven calendar days after receiving the appeal request.

2. Fast Decisions:

- We will make a decision within 72 hours after receiving the appeal request.

Appeal Level 2: If we deny any part of your first appeal, the member or their appointed representative may ask for a review by a government-contracted IRE.

Level 2 External Review

The IRE will conduct a new, impartial review of the appeal and send a written response to the member. If they uphold the BCBSRI decision, they will inform the member of his/her rights to appeal further. If they decide in the member's favor, BCBSRI must authorize services or payment within timeframes specified by CMS.

BlueCHiP for Medicare members have additional appeal rights. Members should refer to their Evidence of Coverage for complete details of all levels of external appeals.

CHAPTER 6

CARE MANAGEMENT

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CARE MANAGEMENT

As a BCBSRI physician/provider, you are required to participate in BCBSRI's utilization management (UM) and case management (CM) and health coaching (HC) programs. We rely on your cooperation to help us implement effective UM and CM programs that will ensure both a positive outcome and cost-effective treatment. Our programs are broad in scope, encompassing the continuum of outpatient and inpatient services delivered by physicians, hospitals, and other healthcare practitioners.

Our UM procedures are in place to ensure that UM decision making is based only upon appropriateness of care and service and existence of coverage. BCBSRI does **not**:

- Reward physicians/providers for issuing denials of coverage.
- Give financial incentives to UM decision makers to encourage decisions that would result in underutilization.
- Use incentives to encourage barriers to care and service.
- Make decisions about hiring, promoting, or terminating physician/providers based on the likelihood that the physician/provider will support or tend to support the denial of benefits.

Utilization Management Program Review

Our UM programs facilitate appropriate delivery of care, coordination of care, and management of high cost and catastrophic care. It also assists to ensure that uniform standards of care are objectively applied, and assesses individual plan coverage criteria.

Our UM programs are the means by which we evaluate the healthcare delivered to our members. They help us to ensure that:

- Medically necessary health services are provided.
- The level of care is appropriate for the patient's medical needs.
- Uniform standards of care are objectively applied.
- Case management screening is universally conducted.

The programs also help us determine which services are eligible for coverage by each plan, and discover any over- or under-utilization of clinical services.

Actions of BCBSRI UM include:

- Reviews for medical necessity and appropriateness of inpatient and outpatient services to determine coverage eligibility
- Coordinates medically necessary care following a member's discharge from the hospital
- Assesses for case management eligibility

Medical Necessity

BCBSRI bases all review determinations on evidence that services are medically necessary and appropriate.

Definition of Medically Necessary

The basis of all our UM programs is the medical necessity and appropriateness of clinical services requested for the treatment of a member's condition. Reviewers examine the medical necessity, appropriateness of the service, and the proposed level of care, based on the following definition of medically necessary:

The use of services or supplies as provided by a hospital, skilled nursing facility, physician, or other provider required to identify or treat a member's illness or injury must be:

- *Consistent with the symptoms or diagnosis and treatment of the member's condition, disease, ailment, or injury*
- *Appropriate with regard to standards of good medical practice*
- *Not solely for the convenience of the member or the member's physician, hospital, or other healthcare provider*
- *The most appropriate supply or level of service that can safely be provided to the member; when specifically applied to inpatient care, it further means that the member's medical systems or condition requires that the diagnosis or treatment cannot be safely provided to the member as an outpatient in an alternative setting*

Resources

Determinations of medical necessity and appropriateness are influenced by UM guidelines developed and published by nationally recognized entities and internally developed proprietary guidelines developed by BCBSRI and the Blue Cross and Blue Shield Association (BCBSA). The resources listed below are available for review:

National medical standards, criteria, and guidelines

- McKesson's InterQual Criteria
- BCBSA, *Technology Evaluation and Coverage Center Manual*
- BCBSA, *Medical Policy Reference Manual*
- Blue Cross and Blue Shield Systems National Transplant Network
- Centers for Medicare and Medicaid Services Online Manual System*
- Medicare Region A DMERC Supplier Manual
- Behavioral health medical necessity criteria as defined by the Behavior Health vendor

** Please reference the Centers for Medicare and Medicaid Services Internet-only Manuals (IOM) for coverage information regarding our BlueCHIP for Medicare members. The IOMs include CMS program*

issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. You can access the IOM at: www.cms.hhs.gov/manuals/IOM/list.asp.

Utilization Management (UM) Program Authority and Responsibility

The Utilization Management Team implements all utilization management program activities. Only qualified staff such as physicians, registered nurses, or healthcare practitioners examine the medical necessity and appropriateness of the services proposed for and provided to BCBSRI members. Appropriate staff conduct an initial evaluation for documentation of medical necessity; however, only physicians can deny reimbursement for services based on lack of medical necessity. If there is insufficient information to clearly support the medical necessity/appropriateness of a particular service, the case will be referred to the BCBSRI medical director or a consulting physician in the appropriate specialty.

IMPORTANT NOTE: If reviewed services fall under the auspices of the vendor organization responsible for reviewing those services (such as behavioral health services or high-tech radiology) the vendor will observe BCBSRI's standards for reviewing and authorizing or denying reimbursement.

Review Information

The Utilization Management Team and UM organizations of vendors responsible for utilization reviews request the medical information necessary to review a case. You are required to provide any medical information and records requested in a timely manner. Any medical records you provide in conjunction with a review are protected by our corporate policies and procedures on confidentiality.

BCBSRI uses utilization management review criteria to conduct medical necessity reviews. To request a copy of the specific criteria used for an individual case, please call the Utilization Management Department at (401) 272-5670 or 1-800-635-2477 (outside of Rhode Island only), 24 hours a day, seven days a week.

Referrals

We recommend that all members obtain a PCP. As a PCP, you are encouraged to coordinate your patients' care with specialty physicians. All BlueCHiP Coordinated Health Plan members must have a PCP and follow referral requirements. For your convenience, a sample Referral Form is included in the Appendix. You can also get forms at the Provider section of BCBSRI.com.

Authorization

Preauthorization is recommended for all elective inpatient admissions and some outpatient services to be covered by a member's benefit plan. However, preauthorization is required for certain services for BlueCHiP for Medicare. *(See Preauthorization Guidelines at the end of this chapter.) Please note, it is always recommended that a provider verify a member's eligibility and benefits in advance of providing services.*

Preauthorization is recommended before services are rendered, unless extenuating circumstances preclude such authorization, or the services are specifically exempted from authorization requirements. Your treatment orders will be reviewed to evaluate the medical necessity of the requested services for the member's condition.

The authorization program reviews the medical necessity and appropriateness of inpatient services and some outpatient services to determine coverage eligibility. It includes these components:

- Pre-service reviews of inpatient or outpatient care (including ancillary services)
- Concurrent reviews of continuing inpatient or outpatient care
- Retrospective reviews of services for which pre-service or concurrent reviews were not performed as required

Expedited Organization Determinations

In addition to yourself, BlueCHiP for Medicare members may request that BCBSRI expedite a determination if they believe that waiting for a decision under the standard time frame could place their lives, health, or ability to regain maximum function in serious jeopardy. While these requests may be submitted directly to BCBSRI either verbally or in writing by the member, you may also fax additional documentation to support the member's request to BCBSRI Utilization Management at (401) 272-8885. If you have any questions, please call the Utilization Management Department at (401) 272-5670 or 1-800-635-2477 (outside of Rhode Island only), 24 hours a day, seven days a week.

Types of Authorization Reviews

BCBSRI's preauthorization reviews evaluate the medical necessity of the service(s) being requested, and verify the appropriateness of the physician/provider, level of care, and site where services will be provided. Reviews are performed at various stages of the treatment process according to the type of service being provided. If you have any questions, please call the Utilization Management Department at (401) 272-5670 or 1-800-635-2477 (outside of Rhode Island only), 24 hours a day, seven days a week.

Pre-Service Reviews

We strongly recommend that you obtain the authorization prior to having services rendered to ensure that the procedure meets our criteria for coverage and to prevent any retrospective denials. Members are not responsible for expenses denied under these circumstances unless they are informed beforehand that the service will not be covered. Preauthorization is recommended for any service that is listed on the preauthorization guidelines grid at the end of this chapter.

Initial reviews of outpatient services consider the extent of requested services and the appropriateness of the treating physician/provider.

Reviews of inpatient services consider the appropriateness of the requested site and level of care, and consider the intensity of service and severity of illness. Usual length of stay for the identified condition and diagnosis is also considered. A nurse reviewer conducts a concurrent review during the member's inpatient stay. We may contact you to gather additional information and insight that is not found in the medical record.

Pre-service reviews for behavioral health admissions are performed by a BCBSRI designated organization with expertise in behavioral health.

Concurrent Reviews

Upon notification of an inpatient admission, the Utilization Management Team may conduct a concurrent review at periodic intervals throughout the member's stay.

Concurrent reviews for behavioral health and chemical dependency admissions are performed by the designated behavioral health vendor as appropriate.

Retrospective Reviews

When a claim is received, we will perform a claims review to determine eligibility for payment. It is recommended that preauthorization be obtained in advance to ensure accurate and timely processing. Such authorization indicates that:

- The provider participates in the network.
- The services are medically necessary.

Because the pre-service review process is so comprehensive, you have the opportunity to raise questions about the review determinations before services are actually provided. In short, pre-service authorization clears a claim for processing provided the member is eligible at the time services are rendered and the services actually received are covered by the member's plan.

When a claim is received, the claim is matched with the record in the Health Operations authorization system. If there is a match and the services are consistent with the authorization, the claim is processed.

If a match does not exist, it will progress to the next level of claim review.

Claims Reviews

The following types of claims for review may be suspended or denied if submitted without notification to BCBSRI (preauthorization):

- Elective inpatient services
- Services rendered by out-of-network/out-of-plan physician/providers
- Elective outpatient services (Refer to Preauthorization Guidelines at the end of this chapter.)
- Durable medical equipment (You can find the form in the Provider section of BCBSRI.com.)
- Select injectables or any other service that may need preauthorization (Please contact the Physician and Provider Service Center for specific information.)

The Utilization Management Team performs a claims review of those services for medical necessity and appropriateness to determine eligibility for payment.

Review for payment options:

The claim is evaluated for payment. First, the member's benefit plan is considered. If the claim cannot be paid, it is subject to a retrospective review for medical necessity.

Review for benefit plan options for BlueCHiP plans:

This step applies when the claim does not contain the referring physician information. It determines whether the claim is eligible for payment under a Flex Plan option.

- If eligible under this coverage, the claim is paid at the lower benefit level for the Flex Plan option, even if the physician/provider participates in the BlueCHiP network.
- If the member's benefit plan does not include options for coverage for unauthorized services, the claim is denied.

Review for medical necessity:

This step applies when there is a discrepancy between the system authorization record and the services for which an authorization number is indicated on the claim.

Payment of the claim is suspended until the review has been completed. It may be necessary to obtain medical records to complete the retrospective review.

If medical necessity cannot be confirmed, the claim is denied.

Claim Denial

The member is responsible:

- When notified of non-coverage in advance by the physician/provider
- When a referral has not been obtained from his/her personal physician as required by his/her plan
- When he or she is not enrolled in a plan with a Flex Plan option
- When the services are other than those to which the member may self-refer

Members may request reconsideration of the denial through the Grievance and Appeals Unit, but physicians/providers are not required to assist in that process.

Physicians/providers are responsible for denials when they:

- Fail to obtain preauthorization for the services for which preauthorization is recommended
- Submit a claim for services that are not consistent with those authorized by Utilization Management
- Do not file claims within timely filing guidelines
- Do not notify the member in advance that he/she will be financially responsible and document that advance notification was given

These denials may be re-evaluated according to applicable procedures. The member is not responsible for charges related to denials that are the physician/provider's responsibility.

Physicians regularly receive Remittance Advice (RA/Settlement) forms reflecting all claims processed during a processing period. Members are not notified of such claims denials. Members may be billed for services when notified in advance by the provider that the health plan has denied reimbursement due to non-coverage on medical necessity.

Appeals Reviews

Refer to Chapter 3.

Access to Out-of-Network/Out-of-Plan Providers

The member's plan will determine the BCBSRI network. Please review the **Out-of-Network** process below.

Exceptions for seeking care outside the network are allowed for:

- Services that are not available within the network
- Emergency care
- Urgent care (when out of the service area)

Coverage

- **BlueCHiP Plan – Flex option** – Members can obtain most services without approval from their personal physician. The member may then select any physician or provider, in or out of network, in exchange for lesser benefits and greater out-of-pocket costs.
- **HealthMate Coast-to-Coast** – Members may choose any doctor or specialist who participates in the local Blue Cross and Blue Shield plan. With network providers, a member simply pays any applicable copayment. No paperwork is involved. For non-network provider services, members are covered at a percent of the allowable amount after applicable copayments and deductibles.
- **Classic Blue** – The BlueCard network links Blue Cross and Blue Shield plans nationwide.

BlueCHiP for Medicare – BlueCHiP for Medicare Core, Standard with Drugs, Plus, and Group Plus plans do not offer point-of-service (POS) benefits. Coverage for services received from out-of-network providers is limited to coverage for emergent or urgent care, renal dialysis, and care that has been pre-approved by the plan or a plan-contracted partner to be received out-of-network. BlueCHiP for Medicare Preferred, Group Preferred, Group Preferred Unlimited, and BlueCHiP for Medicare Value members have a POS benefit, allowing them to receive services from out-of-network providers. Prior authorization does apply for some in-network benefits. Refer to Chapter 7 for additional information on the POS benefit.

Obtaining a Provider

BCBSRI members with national coverage may use participating providers in the BlueCard network. They can locate a provider by calling the BlueCard Program at 1-800-810-BLUE, or use BCBSRI.com. To determine if a physician is in the network, they should see the BCBSRI.com physician directory.

Out-of-Network Process

Call the Utilization Management Team at (401) 272-5670 or 1-800-635-2477 to request preauthorization for out-of-network/out-of-plan services for BlueCHiP for Medicare patients.

- For behavioral health services, pre-service reviews are conducted by the UM agent for BCBSRI's behavioral health administrator.
- For high-end radiology services, pre-service reviews are conducted by the UM agent for BCBSRI's High-End Radiology Program.

The Utilization Management Team will notify you when a determination is made. Personal physicians can make the initial appointment or provide the member with the

necessary information to schedule it. Personal physicians should also follow up with the specialist to monitor the patient's treatment and progress, and request regular written reports, particularly if tests are involved.

Talking with your patient: Give the member clear instructions about the extent of the authorization, including the period of time in which the services must be received and/or the number of days allowed for an inpatient stay. Point out that the referral is specific to a particular physician/provider and that it does not apply to other physician/providers to which the member may have been referred by a treating specialist (except for X-ray and lab tests). Any additional services must be requested and authorized before services are rendered.

Authorizations for inpatient care are limited to the initial length of stay customary for the condition involved. A request to extend the stay will be reviewed and authorized if deemed medically necessary.

Please note: If you have a BlueCHiP for Medicare member who needs interpreter services, please call the Physician and Provider Service Center at (401) 274-4848 to make arrangements. You can find more information on interpreter services on page 26. You can find information on interpreter services for members by calling BCBSRI Customer Service at the number on the back of the member's ID card.

Denials (Out-of-Network)

All requests for out-of-network services will be reviewed by a BCBSRI medical director or a consulting physician/provider.

The Utilization Management Team will notify you of the determination, and follow up with a written confirmation to both the physician/provider and member.

Out-of-Network Options

Some BCBSRI plans have out-of-network coverage that permits members to visit any physician or provider they choose. In turn, members receive lesser benefits and assume greater out-of-pocket costs. Claims for unauthorized services and services from out-of-network physicians/providers are automatically processed according to the plan's out-of-network options.

HMO Blue-USA Away from Home Care Program

Members of BlueCHiP Coordinated Health Plan who are traveling outside the service area are eligible to receive covered benefits through this program. Members simply call **1-800-810-BLUE** and use the indemnity network.

Immunizations

BCBSRI promotes routine preventive immunizations and provides coverage for routine preventive immunizations. We expect all network physicians/providers to be proactive and administer them as appropriate. They may be administered in conjunction with a routine office exam, or in a separate visit just for this purpose. The administration of immunizations does not require preauthorization. For members aged 18 and under, BCBSRI plans follow the State of Rhode Island Vaccine Distribution Policy for routine and at-risk immunizations. For members over age 18, immunizations are covered when medically necessary.

For BlueCHiP plan members aged 18 and under, we follow the State of Rhode Island or Commonwealth of Massachusetts Vaccine Distribution Policy for routine and at-risk immunizations. For members over the age of 18, immunizations are covered when medically necessary.

Vaccine biologicals provided by the state may not be claimed under the member's benefit plan. An exception is made for hepatitis B vaccine agents for members who are eligible for state-sponsored programs.

IMPORTANT NOTE: BCBSRI products do not cover the administration of immunizations and biological that are required for employment or school programs.

Diagnostic Services

The BCBSRI products cover most of the procedures and tests required for diagnostic purposes if the following are met:

- They are covered by the member's benefit plan.
- They are ordered by the member's personal physician.
- They are provided by a network provider.

If you have questions about diagnostic services, please call the Physician and Provider Service Center.

Examples of diagnostic services include:

- Diagnostic imaging, including IVPs, arteriographies, CT scans, and MRIs
- Lab tests on tissue or body fluids
- Echocardiograms
- Holter monitors
- Non-invasive vascular studies
- Neurological studies, including EEG-evoked potentials
- Pulmonary function tests
- Urodynamics, including cystometrograms

- Audiology studies
- Cardiac stress tests, including nuclear imaging

Emergency Services

Emergency services do not require preauthorization. You are required to be available to help the member receive appropriate emergency care.

We give our members explicit instructions for handling a medical emergency. They are encouraged to contact their personal physician before seeking care whenever it is safe to do so, but it is not required.

To qualify as an emergency, the member's condition must meet specific criteria. When applying the following definitions, we consider members' perception of their condition, but we also expect them to seek the advice of their personal physician (or the covering physician).

Definition of emergency care

We cover emergency services in the following situations:

- To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
- If an authorized representative, acting for the organization, authorized the provision of emergency services.

An emergency is the sudden onset of a medical or mental condition with acute symptoms so severe (including severe pain) that without immediate medical attention, it could be reasonably expected by a prudent layperson to result in:

- Placing the patient's health in serious jeopardy
- Serious dysfunction of any bodily organ or part
- Serious impairment to bodily functions, or death—either to himself or herself, or to an unborn child

An emergency medical condition can be related to a physical or mental state as long as it conforms to the above definition.

Procedures

If a member contacts you and you determine that a true emergency (as defined previously) exists:

1. Direct the member to the appropriate site.

You may instruct the member to go to the nearest emergency facility or to call 911, as appropriate.

2. Contact the emergency facility.

Establish and maintain periodic contact with the facility to determine whether your services are needed, and to coordinate follow-up care.

Urgent Care

Urgent care is medical treatment resulting from an unforeseen illness or injury, or exacerbation of a known illness or injury, that is required to prevent serious deterioration of health. Such treatment must typically be rendered within 24 hours of the onset of the condition. Medically necessary urgent care is exempt from service authorization requirements.

- You are expected to determine whether the member's medical needs qualify as urgent and to help your patient obtain urgent care when needed.
- You are also responsible for coordinating any needed follow-up care for the member.

If you refer a member to a non-network facility, please notify us.

BlueCHiP for Medicare – Urgent care services received outside of the United States are not covered. Only emergency care is covered worldwide.

Urgent care is defined by the Code of Federal Regulations the same as an emergency (see previous section), but it is limited to physical or mental conditions requiring medical attention within 24 hours, and does not include dental services.

Copayments for Urgent Care

Check the member's ID card or call BlueLine.

BCBSRI members with a BlueCHiP product may not access urgent care centers for preventive care unless they are exercising their Flex Plan option, subject to any applicable deductible and copayment.

Responsibilities of Urgent Care Centers

When a member's plan requires selection of a PCP, urgent care centers are required to contact the member's PCP within 48 hours to notify him/her of the visit. This will help to provide continuity of care. Centers are also required to send all reports, including lab tests and X-rays, to the PCP within the same time frame. If BlueCHiP plan members do not have a personal physician, the center is required to notify the Physician and Provider Service Center so that we can provide information so that the member can make a selection.

Hospital Discharge Planning

Appropriate care following an inpatient stay helps members recover more quickly and optimizes health outcomes. It also ensures continuity of care by presenting opportunities for frequent monitoring of the member's condition and need for ongoing treatment.

The Utilization Management Team is available to assist with and coordinate medically necessary care following inpatient discharge to the extent that it is covered by the member's plan.

Initiating a Plan

Discharge planning begins when the Utilization Management Team is notified of an acute stay. The patient's progress is monitored throughout the inpatient stay, which enables us to better prepare and service the members. The BCBSRI nurse or on-site review nurse assists the facility discharge planner in coordinating discharge plans.

Developing the Plan

With your help, the BCBSRI nurse develops a discharge plan, coordinating additional services through network providers whenever possible. Case Management may become involved to assist with the complex needs of the member and family.

The discharge plan considers the capability of the member's family or other social supports to act as caregivers, as well as the patient's medical and psychosocial needs, including:

- Alternative lower-level inpatient settings (e.g., acute facility to subacute, skilled nursing facility, rehabilitation facility, or inpatient hospice)
- Home care, including home hospice (exception: BlueCHiP for Medicare hospice benefit is not administered by BCBSRI.)
- Durable medical equipment (beds, walkers, wheelchairs, etc.)
- Home lab draws and other diagnostic services
- Home or outpatient rehabilitation therapies (including physical, speech, and occupational therapy)
- Nutrition counseling
- Postnatal home care
- Transfer transportation by ambulance (e.g., acute facility to home, skilled nursing facility, rehabilitation facility, or hospice)

Service Eligibility

For any of the above services to be eligible for coverage and included in a discharge plan, they must be:

- Covered by the member's contract

- Ordered by the member's attending physician and meet criteria for level of care
- Authorized by BCBSRI prior to discharge for the initial determination of medical necessity of the alternative care site
- Incorporated in a case management treatment plan if post-discharge needs conform to case management qualification criteria

FEP Note: For aftercare services the member must agree to be part of the FEP case management program in order to be eligible for skilled nursing services. The physician must document this discussion with the member and the member must agree.

Procedures

Your participation in discharge planning is usually initiated by a BCBSRI nurse. If you are aware of a patient in need of discharge planning, and have not yet been contacted by either the facility's discharge planner or the BCBSRI nurse, please contact Utilization Management at (401) 272-5670.

To help expedite the discharge planning process:

- Be sure that the nurse knows where to reach you. If appropriate, provide the name and number of your covering physician.
- Help the representative establish contact with the patient's family or support caregivers.

Monitor the patient's progress during the course of the post-discharge plan so that the representative will have appropriate feedback for evaluating the plan's efficacy and for authorizing additional services when appropriate.

Our nurses may contact your patient upon discharge to ensure any ordered services have been delivered, or in some cases, they may recommend additional services. The nurses may contact you for assistance.

Important Message from Medicare for BlueCHiP for Medicare Members

Our BlueCHiP for Medicare members have the right to receive necessary hospital treatment for any disease or injury they have. However, there are benefit limitations for inpatient psychiatric service received in psychiatric hospitals. If they are hospitalized, the attending physician determines when discharge is appropriate.

CMS and BCBSRI believe that it is important for members to understand all of their appeal rights. Medicare enrollees who are hospital inpatients have a statutory right to appeal to a Quality Improvement Organization (QIO) for an immediate review when a hospital and a Medicare health plan, with physician concurrence, determine that inpatient care is no longer necessary.

Hospitals must notify Medicare enrollees who are hospital inpatients about their hospital discharge appeal rights. The term “enrollee” means either enrollee or representative, when a representative is acting for an enrollee. Hospitals will use the Important Message from Medicare (IM) a statutorily required notice, to explain the enrollee’s rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within two calendar days of admission, must obtain the signature of the enrollee or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than two calendar days before discharge.

For those enrollees who request a QIO review, **our participating hospitals have agreed to deliver the Detailed Notice of Discharge (Detailed Notice) as soon as possible, but no later than noon of the day after the QIO’s notification.** Both the IM and the Detailed Notice must be the standardized notices provided by CMS.

Care Coordination Program

BCBSRI’s medical and behavioral healthcare coordination programs help members to improve their health and maintain wellness. Care coordinators provide information and education, assess medication knowledge and compliance, identify available community resources, and provide support to members and their families.

Eligibility

We identify eligible members through utilization management activities, medical, laboratory, and pharmacy claims data, physician/provider referrals, member-initiated referrals, health risk assessments, and personal health assessments. Care coordination generally focuses on members with complex medical and/or behavioral health conditions whose patterns of utilization suggest the member may benefit from additional education, support, resources, or coordination of care to maximize their ability to successfully manage their conditions.

Those who may benefit from our programs include, but are not limited to, members who are experiencing:

- Co-morbid medical and/or behavioral health conditions
- Multiple inpatient admissions or emergency room visits
- Psychosocial issues, such as poor supports, financial barriers, etc., that impact treatment adherence
- Catastrophic conditions requiring close monitoring and coordination of multiple services
- Pregnancy with multiple risk factors

- Conditions such as diabetes, COPD, asthma, coronary artery disease, or congestive heart failure and would benefit from additional education and support to implement treatment recommendations

When a member agrees to participate in our program, the Care Coordinator works with that member to identify specific health goals and action items to assist the member in reaching these goals.

Once the member's goals have been established, the Care Coordinator may fax you a Care Plan for the member, which lists the following:

- Medications the member is currently taking (as identified by the member and/or pharmacy data)
- The interventions (such as providing education and facilitating the use of appropriate resources) that the Care Coordinator will be providing to your patient

We ask that you review the Care Plan, particularly the medications, and sign the form to indicate that the medications are consistent with your records and that you agree with the plan for your patient. Your input is vital to developing and implementing a plan that maximizes the member's potential to successfully manage his or her condition.

Once you return the signed plan via fax, you will receive a \$50 reimbursement for this initial consultation by filing CPT[®] code T2024. (Note this code is effective October 1, 2011.) Certain restrictions may apply. A Care Coordination Associate will inform you of any additional restrictions. Please note that this does not apply to Federal Employee Plan or New England Health Plan members.

Once the Care Plan has been established, the Care Coordinator assists/coaches the member toward achieving his or her goals, monitors the plan (making adjustments as needed), and facilitates communication among the healthcare team. When a member reaches his or her goals or achieves a maximum level of improvement, the member may be discharged from the Care Coordination Program.

Referrals for Care Coordination can come from many sources, including:

- Hospitals
- Discharge planners
- Physicians and other providers
- Social services agencies
- Members
- Families
- Employers (with employee's consent)
- Any agency already providing services to the member

- Internal BCBSRI departments, including Utilization Management, Customer Service, Sales & Marketing, and Grievance and Appeals

Provider Requirements

As a network provider, you are required to participate in BCBSRI programs that target members with chronic or high-risk conditions to provide them with ongoing education about their condition and instructions for managing related care.

Health management programs can help members with chronic or high-risk conditions to:

- Control disease symptoms
- Minimize the need for urgent or emergency treatment interventions
- Improve their health outcomes and quality of life

Members do not bear any additional financial responsibility for services associated with a health management program except for the normal copayments associated with covered services.

Participation

A member's participation is voluntary and the Care Coordination staff performs a comprehensive assessment to identify any issues, barriers, or problems that could impact a member's health.

Physicians/providers know their patients better than anyone and are in the best position to identify situations in which case managers can be helpful. Referring cases to our programs as early as possible benefits members because care coordinators reinforce the physician's treatment plan.

Transition of Care

Members who are new to managed care are often concerned about continuing treatment for an existing condition. Customer Service extends personal assistance to new members who are currently under treatment, helping them quickly adjust to their new personal physician and health plan requirements. As a BCBSRI physician/provider, you are required to assist us as we transition these new enrollees in a manner that ensures continuity of care. We rely on your support to make these transitions as smooth as possible.

Prior to enrollment, we ask new members to inform us if they have a chronic or temporary condition that warrants immediate transfer of a specific treatment protocol, including pharmaceutical therapies that should not be interrupted. Transferring members are also asked to let us know if they are currently under treatment.

BCBSRI helps these members select a personal physician who can accommodate their current or chronic treatment needs, as well as specialists and other physicians/providers who may be needed immediately upon their enrollment effective date. We ensure that all arrangements are in place as of the effective date, including the transfer of medical records, scheduling of appointments needed soon after enrollment, and an introduction to the new physician(s) and provider(s).

Pregnant Members

New members in the third trimester of pregnancy may remain with their current physician through delivery and one postnatal visit. They may prefer to transfer to a network personal physician or OB/GYN as of their effective enrollment date, but should keep in mind that physicians/providers are not obligated to accept new members in the third trimester of pregnancy.

If it is medically safe to transfer the member's care, Customer Service will try to locate a physician/provider who will agree to accept the member.

Personal Physician Changes

The transition assistance program also applies to enrolled members under treatment who request a new personal physician. The current physician is required to help with the transfer of medical records, discussing the member's condition with the new physician(s), and providing any other assistance requested by either Patient Care Services or the new physician(s).

If it is not medically safe to make the transfer, the present physician will need to complete treatment. The transfer will not become effective until the treatment is concluded.

Clinical and Preventive Healthcare Guidelines (Practice Guidelines)

BCBSRI's practice guidelines are based on medical evidence and published standards accepted by the medical community. They promote prevention at the primary, secondary, and tertiary levels.

We periodically review practice and treatment guidelines to ensure that they are current, clinically appropriate, and in alignment with our health improvement initiatives and benefits. Also, whenever guidelines imposed through a regulatory agency are more stringent than those recommended by a medical organization, we will adopt them for application to the member population governed by that agency.

Practice guidelines are presented to the Professional Advisory Committee (PAC) for review and approval for both content and purpose. Upon approval of the MPRC, the

Executive Quality Council (EQC) is notified of all approved practice guidelines. Minutes reflect the decision process regarding inclusion and/or exclusion of guidelines, as well as content and use. Reviews of adopted guidelines and proposed additions or deletions are conducted at least once every two years, and providers are notified of those review results and changes in a timely manner online via the monthly *Provider Update* newsletter. A listing of practice guidelines is also available by logging in to the secure Provider site on BCBSRI.com.

Elements of Preventive Care

BCBSRI elects to have Commercial plans accredited by the National Committee for Quality Assurance (NCQA), which makes a distinction between preventive health services and other clinical care. In the interest of clarity, we make this distinction as well.

Commercial plans promote prevention in the following ways:

- Full coverage for routine exams and immunizations
- Reminder phone calls and/or letters about important health screenings
- Worksite wellness program
- Listings of community resources, including influenza and pneumonia clinics, senior health fairs, and other health-related community events
- Access to advice and information about quality health and wellness services, tools and guides to learn about healthcare options, and discounts and savings on health-related programs through Blue 365

BCBSRI considers prevention activities to be part of general health management, and we have tertiary programs under the umbrella of our quality improvement initiative.

Resources

The resources used by BCBSRI in evaluating preventive care guidelines include:

- *U.S. Preventive Services Task Force: Guide to Clinical Preventive Services*
- *Centers for Disease Control: General Recommendations on Immunizations*
- Rhode Island Department of Health Early Prevention Screening, Diagnosis and Treatment Program (EPSDT)

Also, for infants, children, and adolescents:

- American Academy of Pediatrics

And for prenatal care:

- U.S. Preventive Services Task Force: Guide to Clinical Preventive Services, USPHS
- Public Health Service Expert Panel on the Content of Prenatal Care

Help Members Take Charge of Their Health

We provide integrated health management programs at an appropriate level to members along the healthcare continuum, from those who are healthy to those with chronic conditions and complex healthcare needs.

On a monthly basis, members are identified for Asthma and Diabetes Disease Management and stratified by risk levels. The risk level determines the level of intervention, which is designed to support members with condition monitoring, adherence, lifestyle changes, and other health issues. Clinical practice guidelines assist in the clinical decision-making required to diagnose and assess severity of eligible members. These guidelines are also used to design interventions to effectively identify and manage our population.

Disease Management programs are delivered via a combination of mailings and telephonic health coaching focused on closing gaps in care, improving medication compliance, and providing education and support. Members at high risk are invited to “opt in” to health coaching. Central to all interventions and initiatives are efforts to collaborate with and engage the member’s physician. This collective and collaborative effort empowers members to live healthfully, confident in their ability to manage their disease/condition.

If you would like to refer one of your patients to Disease Management or Health Coaching, please call (401) 459-2273.

Asthma Program

The Asthma Program is designed to help our members better manage their disease and improve their quality of life. Members are offered education tools and resources through telephonic outreach, direct mail, and BCBSRI.com. Health coaching is also available for pediatric and adult members with uncontrolled asthma.

Diabetes Program

The goal of the Diabetes Management Program is to decrease diabetes-related morbidity by increasing the member’s ability to comply with self-monitoring activities and lifestyle changes. Members are offered educational tools and resources through telephonic outreach, direct mail, and BCBSRI.com. Health Coaching and reminders for important diabetes-related exams and tests are available for adult members with diabetes. A Health Coach may be a nurse, dietitian, or a certified diabetes outpatient educator.

Senior Health and Fitness

We understand that staying healthy after age 65 requires extra attention and support. To encourage our Medicare Advantage members age 65 and over to be proactive in addressing their health needs, we can send them a comprehensive guide to appropriate health screenings for their age, common health concerns, physical activity information, and information on flu and pneumonia prevention.

Seniors also receive appropriate telephone calls reminding them of the importance of colorectal and breast cancer screenings, and influenza and pneumonia immunizations.

Health Assessment

This completely confidential questionnaire is available to all members on BCBSRI.com or via a worksite wellness initiative through our Wellness Works™ product. The Health Assessment helps members learn more about their personal health, the lifestyle choices they make that impact their health, and their personal attitudes about health and work. Members are asked a series of questions about their health risks, medical conditions, life satisfaction, and work and lifestyle habits. Upon completion, each member immediately receives a customized Personal Health Profile that includes comprehensive, personalized information outlining his or her individual health risks and practical suggestions to help him or her lead a healthier life.

Wellness Portal

A wellness portal provides participants with access to the Health Assessment, a variety of web-based workshops, trackers, and health information. In addition, it allows tracking of participation in all wellness activities for easy implementation of incentive programs.

The new wellness portal includes:

- Personal Wellness Record
- Individual Health Dashboard
- Comprehensive Health Assessment
- Customized Nutrition and Exercise Plans
- Ask an Expert
- Wellness Challenges – Weight management, exercise minutes, walking and nutrition
- Health Resource Library – Articles, educational videos, symptom checker, healthcare decision tools
- Online Wellness Workshops featuring these topics:
 - Exercise
 - Back care
 - Nutrition
 - Diabetes Prevention
 - Personal Goal Setting (Ready, Set, Goal)
 - Weight Management – Losing It
 - Weight Management – Maintaining It
 - Smoking Cessation
 - Cardiovascular Health
 - Stress Management

- Healthy Tailgate
- Healthy Holidays
- Personal Goal Setting

Wellness Trackers

Achieving optimal wellness begins and ends with moving more and eating better each day. Our online Wellness Trackers can help individuals to keep track of their daily physical activity and food habits, and balance their daily caloric intake to achieve their weight management goals.

- The **Physical Activity Tracker** allows the user to log activities by type, include the intensity level, and note how much time is spent being active.
- The **Nutrition Tracker** allows users to record daily food choices. The tracker also calculates the number of calories burned at rest and during a reported activity, and how many calories are taken in over the course of a day.
- **Biometrics trackers** include the capability to track blood pressure, cholesterol, and blood glucose on daily, weekly, or monthly intervals.
- **Fruit and vegetable serving trackers** allow members to track daily intake and view weekly and monthly trends.

By using the Wellness Trackers each day, individuals see how small changes to daily activity and dietary habits can add up to better health. Over time, making smart choices and balancing daily calories will help individuals control their weight and stay healthy.

Worksite Wellness

For worksite clients that offer BCBSRI's Wellness WorksTM product, employees can participate in interactive and educational wellness programs at the worksite. These programs are designed to make health education convenient for the working population, and empower members to make lifelong, healthy lifestyle changes. Topics include:

- | | |
|---------------------|--------------------------|
| • Physical Activity | • Women's Health |
| • Nutrition | • Men's Health |
| • Self-Care | • Family Health |
| • Back Care | • Healthcare Utilization |
| • Weight Management | • Disease Prevention |
| • Smoking Cessation | • Sleep |
| • Stress Management | • Ergonomics |

Community Wellness

BCBSRI is dedicated to improving the health of all Rhode Islanders. Community events offer screenings, flu shot clinics, physical fitness classes and events, health education, and lectures that are open to anyone in the Rhode Island community. **BCBSRI membership is not required to participate in community events.**

Preauthorization Guidelines

In Plan

Preauthorization is required for certain imaging services, a list of which you can find in the Provider Section of BCBSRI.com. Preauthorization is also required or recommended (based on the plan) for a number of other services, all of which you can find in our medical coverage policies, which are provided in the same section of BCBSRI.com.

The chart on the next page indicates with a “Y” some common services for which preauthorization is:

- Required for BlueCHiP for Medicare
- Recommended for all other products

Preauthorization allows us to review and determine the medical necessity of a service and/or the appropriateness of the setting.

In addition, we recommend preauthorization before services are performed outside the local participating provider network. Obtaining preauthorization ensures that your claims will not be retrospectively denied for lack of medical necessity or for being experimental or investigational.

Failure to obtain preauthorization may result in your financial liability for all or part of the cost of services if the services are determined to be not medically necessary, are experimental, or investigational. The chart does not attempt to indicate reimbursement levels.

Again, this is not an all-inclusive list of services for which preauthorization is recommended or required. Please refer to the medical policies located in the Provider section of BCBSRI.com for more specific information or call the Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050.

PRODUCTS

	BlueCHiP for Medicare	BCBSRI Managed Care Products	New England Health Plans Products
SERVICES			
Carotid Stents	Y	Y	Y
Cosmetic Procedures	Y	Y	Y
Inpatient Facility (Acute, SNF*, and Rehab)	Y	Y	Y
Inpatient Hospice	N	N	N
Hyperbaric Oxygen	Y	Y	Y
Air Ambulances	Y	Y	Y
DME**	Y	Y	Y
Speech Therapy	Y	Y	Y
Private Duty Nursing	NC	Y	Y
Radio Ablation of Renal Tumors	Y	Y	Y
Behavioral Health/Substance Abuse Inpatient Services***	Y-1	Y-1	Y-2
Behavioral Health/Substance Abuse Partial Programs***	Y	Y	Y
Residential Substance Abuse Services***	Y	Y	Y
Behavioral Health/Substance Abuse Intensive Outpatient Programs***	Y	Y	Y
Behavioral Health Children/Adults Intensive Services***	NC	Y	Y
Injectables [†]	N	N	N
Outpatient Pulmonary Rehab	Y	Y	Y
Organ Transplants	N	N	N
Termination of Pregnancy [†]	Y [†]	N	N
Dental Procedures in the Outpatient Setting	Y	Y	Y
High-End Radiology	Y	Y	Y

Footnotes:

NC=not covered

1 = Behavioral health and chemical dependency preauthorizations are processed by our behavioral health vendor. Providers may access the behavioral health vendor by calling the BCBSRI Behavioral Health Line at (401) 277-1344 or 1-800-274-2958.

2 = Behavioral health and chemical dependency preauthorizations are processed by the Home Plan's behavioral health vendor.

*There is no preauthorization for SNF admissions for any product line. However, notification of admission from the SNF provider is required.

** Preauthorization for DME – Please refer to the “DME Rent to Purchase, Repair, and Replacement” policy on BCBSRI.com.

***For Federal Employee Program (FEP) members, prior authorization is required for inpatient services, partial programs, residential substance abuse services, intensive outpatient programs, children's/adults' intensive services, outpatient professional services, and select outpatient services.

[†]Preauthorization for selective injectables. Contact the Physician and Provider Service Department for more information.

BlueCHiP for Medicare: Termination of pregnancy is only covered in incidences of rape or incest, or when the mother's life is in danger.

BlueCHiP Plan PCP Referral Rules for Participating Providers

PRODUCTS

	BlueCHiP Coordinated Health Plan	HMO BLUE NE/Blue Choice NE
Behavioral Health – Routine Outpatient	N	N
Childbirth/Prenatal Classes	N	N
Diabetic Education	Y	Y
Nurse Practitioners/Phys. Assistants	Y	Y
OB/GYN (Routine and Medical)	N	N
Oncology/Hematology	N	N
Oral Surgeon	N	N
Outpatient Surgery (Surgeon)	Y	Y
PCP Visits	N	N
PT/OT	Y	Y
Prenatal Classes	N	N
Smoking Cessation	N	N
Specialist Visits	Y	Y
Vision Exams (Routine and Medical)	N	N
Walk-in Urgent Care Centers	N	Y

This document is not intended to state a member's benefits or to verify coverage. For your convenience, a sample Referral Form is included in the Appendix. You can also get forms at the Provider section of BCBSRI.com.

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CHAPTER 7

BENEFIT PLANS AND CLAIMS ADMINISTRATION

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BENEFIT PLANS AND CLAIMS ADMINISTRATION

One of the many attractive features of BCBSRI is its low out-of-pocket costs for members. In addition to a monthly premium, our plans include cost-sharing features for specific services to help keep them affordable. For example, members have the advantage of being able to visit physicians/providers who agree to accept our payments or reimbursement as payment in full.

Physicians/providers may collect only the copayment and deductible amounts specified by a member's plan, and applicable charges for services that are not covered by the plan. As a participating physician/provider, you are required to honor any maximums applicable to those out-of-pocket amounts and hold the member harmless from charges exceeding amounts allowed by BCBSRI for covered services.

Copayments, Deductibles, Coinsurances, and Out-of-Pocket Maximums

When a copayment, deductible, and/or coinsurance is due from the patient, your office may collect the specified amount directly from the member, as outlined below.*

Copayments

A copayment is a fixed payment (not a percentage) made for the member's share of the cost of certain covered services they receive. Copayments generally are associated with routine services, such as office visits, exams, prescriptions, and emergency room visits. The copayment amount may vary depending on the member's plan.

The member pays the copayment at the time of service, unless you choose to bill at a later date.*

Alternately, you may accumulate copayments and bill the member for them, requesting payment by a certain date. If providers within a medical group use a central business office, that office also may collect the copayments due.

** All Qualified Medicare Beneficiaries, as defined by the state of Rhode Island, are to be held harmless for all applicable copayments/coinsurances. Providers must either accept the Medicare Advantage plan payment as payment in full or bill the appropriate state source for the services received by these members. The exceptions to the hold harmless provision are: the Living Fit benefit, wig coverage, hearing aid coverage, vision hardware, and Part D prescription drug copayments.*

Physicians/providers cannot bill BCBSRI for missed appointments. However, you may charge members a copayment or bill members for missed appointments at your own discretion, as long as this is consistent with your office policy for non-BCBSRI members. This, however, applies only to our commercial and BlueCHiP for Medicare products. However, BlueCHiP for Medicare members who are considered Qualified Medicare Beneficiaries are to be held harmless and cannot be charged for missed appointments.

Physicians/providers should notify the Physician and Provider Service Center of noncompliant members and we will follow up with outreach and education.

Deductibles

A deductible is a fixed dollar amount that a member must pay before the health plan starts to pay for its share of certain medical bills. It resets each year (per calendar year or plan year). Although a deductible is a specified amount, and may vary depending on the member's plan, it often accrues from a number of services, with the services of several providers contributing to the amount.

Coinsurances

A coinsurance is a percentage of the allowable fee for a particular service. The coinsurance percentage may vary depending on the member's plan. You may collect the coinsurance at the time of service (except for those members covered by one of our BlueCHiP for Medicare plans) as long as you know the appropriate coinsurance percentage for that member's plan as well as the allowable amount for the service(s) rendered.

Out-of-Pocket Maximums

Out-of-Pocket Maximums for Commercial Members

Out-of-pocket maximums protect members against large medical expenses by capping the total amount they could pay for essential health benefits in a year. All in-network medical and pharmacy copayments, deductibles, and coinsurance apply to the in-network out-of-pocket maximum. The out-of-pocket maximum amount may vary depending on the member's plan and may be different depending on whether members see in-network or out-of-network providers.

In-Network Out-of-Pocket Maximums for BlueCHiP for Medicare

All in-network Medicare-covered Part A and Part B services apply to the plan in-network out-of-pocket maximum. Once a member has reached the yearly maximum, BCBSRI pays 100 percent of the allowable fee for covered services. Please call BlueLine or visit BCBSRI.com for the applicable BlueCHiP for Medicare Plan out-of-pocket maximum. All BlueCHiP for Medicare plans, including BlueCHiP for Medicare employer group plans have an in-network out-of-pocket maximum to which all in-network Medicare-

covered Part A and Part B services apply. Prior to collecting a copayment or coinsurance from a member, please call BlueLine or the Physician and Provider Service Center to confirm that the member has not yet reached their out-of-pocket maximum.

If your provider settlement reflects an overpayment, please contact the Physician and Provider Service Center so that it can be determined if the overpayment is due to your office collecting a copayment or coinsurance from a member who had met his or her out-of-pocket maximum. If you did collect a copayment or coinsurance after the member had met his or her annual out-of-pocket maximum, you must reimburse them.

Out-of-Network Out-of-Pocket Maximums for BlueCHiP for Medicare

For information on the BlueCHiP for Medicare Value, Preferred, Group Preferred, and Group Preferred Unlimited point-of-service benefit and the applicable point-of-service out-of-network, out-of-pocket maximum, please refer to page 136.

PLEASE NOTE: Self-referral options are available under all commercial BlueCHiP plans for specific services, but the services must be received from network physicians/providers. BlueCHiP for Medicare members do not need referrals from their primary care physician to see an in-network specialist.

“Hold Harmless” Provisions

Your contract with BCBSRI expressly states that you may not bill, charge, collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a member (or person acting on the member’s behalf) for services covered by the member’s benefit plan. This provision does not apply to copayment, coinsurance, and/or deductible dollar amounts, or charges for services not covered by the member’s benefit plan; these are the full responsibility of the member.

Procedures

1. Determine whether the member’s plan specifies a copayment, deductible, and/or coinsurance for your services.

The member’s BCBSRI ID card will indicate the member’s particular plan. Copayment amounts are indicated on member ID cards. Deductible information, along with coinsurance information, is available by contacting the Physician and Provider Service Center. To find out how much of the deductible is remaining (deductible balance), please log in to the secure Provider site on BCBSRI.com or call the Physician and Provider Service Center.

2. Collect the appropriate copayment, deductible and/or coinsurance amount from the member.

Providers must follow the procedure below:

- Collect the applicable deductible from the patient at the time of the service once you have verified with BCBSRI that the patient has not met their deductible. Verification of the most up-to-date deductible balance information can only be obtained by contacting the Physician and Provider Service Center and speaking to one of our representatives.
- Collect the appropriate coinsurance from the patient at the time of service when the provider knows the allowance for the service(s) provided. You can verify a member's coinsurance information by logging in to the secure Provider site on BCBSRI.com, by calling BlueLine, or by contacting the Physician and Provider Service Center.
- Continue to collect the copayment at the time of service. A member's copayment information can be obtained from the member's BCBSRI identification card, by logging in to the secure Provider site on BCBSRI.com, by calling BlueLine, or by contacting the Physician and Provider Service Center.

For BlueCHiP for Medicare members: Providers may collect the appropriate copayment or coinsurance amount from the patient at the time of service, except from BlueCHiP for Medicare members, who are considered Qualified Medicare Beneficiaries as defined by the state of Rhode Island. Prior to collecting the copayment or coinsurance, providers must verify patient eligibility and benefit information. You can do this by logging in to the secure Provider site on BCBSRI.com, by calling BlueLine, or by contacting the Physician and Provider Service Center.

When consulting with the Physician and Provider Service Center concerning a member's deductible balance, please keep in mind that claims are processed in the order received. As a result, member liability could change from the date of your inquiry to the date the claim is finally processed.

Providers should be mindful of their legal and ethical obligations for providing care.

Members are fully responsible for payments due directly to you or your billing office. Those who do not meet their financial responsibilities may face corrective action by BCBSRI.

Subject to your legal and ethical obligations, and your written office policy, you may discontinue the doctor (or healthcare practitioner) patient relationship if the patient has longstanding, unpaid balances.

If you collect the applicable deductible/coinsurance at the point of service and are ultimately reimbursed directly from BCBSRI, you are required to refund the member no later than 45 days after receipt of the Remittance Advice (RA/Settlement) form.

3. Waive charges for services that exceed the BCBSRI allowable fees.

You must accept the fees or capitation amounts specified in your contract (less any applicable copayments and deductibles) as full compensation for services provided to members. You may not bill members for any difference between the allowed amount and your normal charges.

BCBSRI Commercial Plans

Classic Blue

BCBSRI's traditional indemnity plan is offered to employer groups located in Rhode Island.

HealthMate Coast-to-Coast

HealthMate Coast-to-Coast is BCBSRI's traditional preferred provider organization (PPO) plan with copayments, coinsurance, and deductibles. Some plan designs include calendar year or plan year deductibles.

BasicBlue Direct

BasicBlue Direct offers coverage for many in-network services with no copayments or coinsurance once the deductible is met. This plan is available to people under age 30, those experiencing financial hardship, or those who cannot afford more costly coverage. (Specific eligibility requirements apply to this plan.)

BlueSolutions and BlueSolutions Direct

BlueSolutions is a high-deductible health plan that allows employers and members the option to set up a health savings account (HSA) so they can save pre-tax dollars for current and future medical expenses.

BlueSolutions SelectRI

BlueSolutions SelectRI is the BlueSolutions plan coupled with the SelectRI network. SelectRI is an innovative network option that empowers members to get the care they need at the lowest cost. They'll still have the flexibility to choose any provider in our national network, but when they use SelectRI providers, they'll have the lowest out-of-pocket costs and access to comprehensive primary care with many extra services.

VantageBlue and VantageBlue Direct

VantageBlue is designed with special benefits to help empower members to get healthy. The plan features special incentives like low or zero copayments that encourage

preventive care such as routine exams and screenings. VantageBlue features our national network of healthcare providers.

VantageBlue Select

This plan couples VantageBlue with the Select preferred network option. The Select network provides guided care with unique access to coordinated and comprehensive care, concentrated in the Providence County area. Selection of a primary care physician (PCP) is required.

VantageBlue SelectRI and VantageBlue SelectRI Direct

This plan couples VantageBlue and VantageBlue Direct with the SelectRI network. This tiered network option empowers individuals, families, and employees to get the care they need at the lowest cost. They'll still have the flexibility to choose any provider in our national network, but when they use SelectRI providers, they'll have the lowest out-of-pocket costs and access to comprehensive primary care with many extra services.

BlueCHiP Coordinated Health Plan (BlueCHiP)

BlueCHiP plans offer several variations on our coordinated care plan to group employers located in Rhode Island and those whose employees reside in the Rhode Island service area. Some plans include a Flex Plan option that allows members to visit non-network providers or see a network physician/provider without a referral.

All Plans

- BCBSRI conducts all enrollment, membership, and customer service activities, and processes all claims.
- BCBSRI performs all reviews for medical necessity and service authorizations (except for certain services such as behavioral healthcare, which are performed by BCBSRI's contracted administrators).
- BCBSRI manages all complaints, grievances, and utilization management appeals (except for certain services such as behavioral healthcare, which are performed by BCBSRI's contracted administrators). This does not apply to BlueCHiP for Medicare.

BlueCHiP for Healthy Options

This plan offers traditional coverage with predictable copayments and a lower deductible.

Flex Plan Option

Some commercial plans include a Flex Plan option, which allows members to see any physician/provider, in or out of the network, without a referral from their personal physician. Members are required to obtain preauthorization for inpatient services when

utilizing non-network physicians/providers. (Network physicians/providers are still required to obtain preauthorization reviews for inpatient admissions to out-of-network facilities.)

In exchange, members incur greater out-of-pocket costs, including higher copayment amounts and an annual deductible. There is an annual maximum on the amount of deductibles and out-of-pocket expenses members must pay. Once that limit is reached, BCBSRI pays for covered services, up to its allowance for a particular service.

The Flex Plan option is available with BlueCHiP Coordinated Health Plan only, and is indicated on the member's ID card.

Flex Plan Coverage

The Flex Plan option usually does not allow members to directly access ancillary services that normally require a physician's orders, such as lab tests, X-rays, etc.

The Flex Plan option usually covers many of the same services covered by the member's core plan, but the actual range of covered services may vary. Services that are not covered by a Flex Plan option include, but are not limited to:

- Behavioral healthcare
- Skilled nursing facility services
- Rehabilitation hospitals
- Outpatient physical, occupational, or speech therapy
- Vision services
- Chiropractic visits
- Organ transplants
- Any service not covered, or specifically excluded from, the member's core plan

Compensation for Flex Plan Services

When a member exercises the Flex Plan option to see a network physician/provider, services are compensated (up to BCBSRI's allowance) as fee-for-service, even if the physician's/provider's usual arrangement is capitation.

When a member uses the Flex Plan option to go outside the network, the member is responsible for full charges and BCBSRI reimburses the member based on the BCBSRI fee allowance less the applicable copayment and/or deductible.

Procedures

1. Determine whether the member has, and is exercising, the Flex Plan option.

When scheduling an appointment:

If you are a PCP and the member is not enrolled with you, or you are a specialist and you have not received a referral from the member's personal physician, be sure to advise the member that he or she is responsible for all charges for your services. Make sure this discussion is documented in the patient's file or the member signs a self-referral acknowledgement form, since these services will not be covered unless they are needed urgently or are for an emergency, unless the member has the Flex Plan option.

At time of service:

Ask for the member's ID card to check for the Flex Plan.

When referring the member to other physicians/providers, or ordering services:

Ask whether the member intends to exercise the Flex Plan option. If so, you may proceed with ordering ambulatory services without first obtaining authorization from Utilization Management. Otherwise, you should follow applicable authorization procedures. You must always follow authorization procedures for inpatient care.

2. Collect applicable coinsurance and deductibles.

Coinsurance and deductible amounts for Flex Plan services are different from those for services covered by the member's core plan. Physicians/providers may only collect deductible amounts from the member after verifying with BCBSRI that the member's deductible has not been met. Members seeking care from non-network physicians/providers will be responsible for paying the physician/provider directly and submitting claims for reimbursement.

3. Submit a claim for services.

You must submit a claim to BCBSRI for all services provided to members, whether or not they are exercising their Flex Plan option. If you are a physician/provider with a fee-for-service compensation arrangement, simply submit your claim as usual. Capitation arrangements do not apply for Flex Plan services.

BCBSRI Government-Funded Plans

The health plans available to beneficiaries of government entitlement programs must meet stringent requirements mandated by legislation. Delivery of services to those populations is monitored by regulatory agencies charged with the responsibility of safeguarding the integrity and economic stability of the entitlements.

BlueCHiP for Medicare

Description

BlueCHiP for Medicare plans are Medicare Advantage plans offered by BCBSRI. To enroll, Medicare beneficiaries must be entitled to Medicare Part A and enrolled in Part B, and live in the service area. Individuals with End-Stage Renal Disease (ESRD) are generally not eligible to enroll in BlueCHiP for Medicare unless they are members of our organization and have been since their dialysis began. Coverage includes all Original Medicare-covered benefits plus additional benefits. All plans provide coverage for inpatient care, preventive care, and emergency/urgent care. In 2014, five individual plan options are available to permanent residents of Rhode Island: BlueCHiP for Medicare Value, Core, Standard with Drugs, Plus, and Preferred. There are also three retiree group options available to permanent residents of Rhode Island, Bristol County, Massachusetts, and certain areas of New London County, Connecticut: Group Plus, Group Preferred, and Group Preferred Unlimited. All plan designs except BlueCHiP for Medicare Core include Medicare Part D prescription drug coverage. Benefits, premiums, and copayments are offered on a calendar year basis and must be approved by the Centers for Medicare & Medicaid Services (CMS).

All BlueCHiP for Medicare members who are defined as Qualified Medicare Beneficiaries by the state of Rhode Island are to be held harmless from all applicable copayments/coinsurances. Providers must either accept the Medicare Advantage plan payment as payment in full or bill the appropriate state source for the services received by these members. The exceptions to the hold harmless provision are: the Living Fit benefit, wig coverage, hearing aid coverage, vision hardware, and Part D prescription drug copayments.

Your provider settlement from BCBSRI will identify the members the Federal Law applies to. If a BlueCHiP for Medicare member who is considered a Qualified Medicare Beneficiary loses his or her Medicaid eligibility, it will be reflected on your BCBSRI provider settlement.

Please reference the Centers for Medicare and Medicaid Services Internet-only Manuals (IOM) for coverage information regarding our BlueCHiP for Medicare members. The IOMs include CMS program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. You can access the IOM at: www.cms.hhs.gov/manuals/IOM/list.asp and then reference Publication #100-16 for the Medicare Managed Care Manual.

Features

- BCBSRI conducts all enrollment, membership, and customer relations activities and pays all claims (except claims for hospice and services received when a member is on hospice* and Part D claims).
- BCBSRI performs all authorization and service reviews (except for certain services such as behavioral healthcare, high-tech radiology services, and Part D drugs, which are performed by BCBSRI's contracted administrators).
- BCBSRI manages all complaints and appeals (except for certain services such as Part D drugs, which are performed by BCBSRI's contracted administrator); CMS' contractor provides reconsideration of appeals when BCBSRI upholds denials.

* **Hospice-eligible BlueCHiP for Medicare Members:** When a BlueCHiP for Medicare member becomes hospice-eligible, CMS will notify BCBSRI. While a member is on hospice, BCBSRI is not responsible to pay for services other than non-Medicare reimbursable services starting the first of the month following his or her eligibility. Non-Medicare reimbursable services include:

- Wigs
- Vision hardware
- Hearing aids
- Living Fit benefit
- Routine hearing, routine vision exams, and routine podiatry
- Annual physical
- Contraceptives
- Organ transplant trip-related expenses
- Dental services (employer group plans)

BCBSRI will continue to deny other services for the provider to file with Medicare until the last day of the month of the BlueCHiP for Medicare member's hospice eligibility end date.

Medigap Plans

Medigap plans help pay for costs that are not paid by Original Medicare, including deductibles, coinsurance, and more. BCBSRI offers Plan 65 as a supplement to Original Medicare coverage. In 2014, the following supplemental plans were offered at BCBSRI:

Plan 65 A – Provides basic coverage at lower rates. Plan 65 A does not cover Medicare Part A and Part B deductibles or the daily skilled nursing facility (SNF) coinsurance.

Plan 65 C – Offers maximum benefits and flexibility. Plan 65 C pays the daily SNF coinsurance, Part A & B deductible and includes coverage for foreign travel at 20% coverage after \$250 deductible, up to a \$50,000 lifetime maximum.

Plan 65 Select C – Offers maximum benefits at a lower cost. Plan 65 Select C offers the same coverage as Plan 65 C but has a network of participating hospitals that members must use, except in emergencies or if the services are not available in network and have been approved by the plan to be received out of network.

The Plan 65 B, Select B, and Select L plans are no longer open for new enrollments. Only existing members may retain their enrollment in these plans.

Age-In Credit Program for Plan 65

BCBSRI offers the Age-In Credit program, which is available to prospects who enroll in Plan 65 plans within (6) six months of becoming eligible for Medicare Part B, or for those who enroll within 63 days of losing group coverage through their own or their spouse's active employment. The Age-In Credit Program offers a 30 percent discount on the plan rate for the first year a member is enrolled, a 20 percent discount in the second year, and a 10 percent discount in the third year. After the third year, the standard rate for the plan option applies.

Member Self-Referral Benefits

BlueCHiP for Medicare members do not need referrals to see in-network specialists. Members of commercial BlueCHiP plans, NEHP, and BlueCHiP for Healthy Options may self-refer to a network provider for certain services. A referral from their personal physician is not required. Self-referred services are covered at the same level as other services, and are subject to the same copayments, limitations, and exclusions outlined by the plan. For those services that do require a referral, see the Appendix for a sample Referral Form.

Members of BlueCHiP plans and NEHP may self-refer for the following:

Obstetrician and Gynecological Visits

Female members may self-refer to a network OB/GYN for annual routine exams, including related preventive screenings such as Pap smears and mammograms as well as any other gynecological services.

Chiropractic Medicine

Depending on their BCBSRI option, members may self-refer for a set number of visits for medically necessary chiropractic services.

NOTE: BlueCHiP for Healthy Options members do not have coverage for chiropractic services. BlueCHiP for Medicare chiropractic coverage is limited to the Original Medicare benefit, manual manipulation of the spine to correct subluxation.

Behavioral Health

Behavioral health services do not require a referral. However, for BlueCHiP for Medicare, prior authorization is required for inpatient behavioral health stays as well as certain outpatient behavioral health services, including covered intensive outpatient services. For NEHP members, please consult with the member's home plan. Each home plan may have different referral or authorization requirements.

Oncology

Out-of-Area Renal Dialysis

BlueCHiP for Medicare members are covered for out-of-area renal dialysis when temporarily out of the service area. The in-network copayment will apply.

Pregnancy and Maternity Care

Members may receive this care from their personal physician, or from a network OB/GYN. It is the participating OB/GYN's responsibility to notify BCBSRI via the prenatal notification form of any confirmed BCBSRI member's pregnancy. The hospital stay for delivery must be authorized in advance, except in emergencies.

Urgent and Emergent Care

For BlueCHiP for Medicare plan members, authorization from the plan is not required if a member is out of network during an emergency or if urgent care is needed. In either case, the in-network copayment will apply. BlueCHiP for Medicare includes coverage for worldwide emergency care only. (Some non-Medicare plans may require a referral for urgent care. Please verify via BlueLine or BCBSRI.com).

Vaccinations for Flu and Pneumonia

This applies to BlueCHiP for Medicare members only.

Vision Care

Members may self-refer to a participating optometrist or ophthalmologist for eye care services. (Some plans may require a referral for vision care. Please verify via BlueLine or BCBSRI.com).

Voluntary Termination of Pregnancy

Members do not need referrals from their personal physician or an authorized obstetrician. These procedures are managed as outpatient surgeries; BCBSRI may require that they be performed at specific facilities. Certain criteria must be met for BlueCHiP for Medicare.

BlueCHiP for Healthy Options

Members of BlueCHiP for Healthy Options may self-refer for the following:

- Emergency care (emergency room services and ambulance services)
- Freestanding emergency medical centers (for urgent care if you cannot contact your *primary* physician)
- Obstetricians and gynecologists

Benefits for BlueCHiP for Medicare

(Benefits may change annually. Providers will be notified of any changes at least 60 days prior to the changes being effective. This notification will be sent out via Provider Update.)

- **Interpreter Services** – BlueCHiP for Medicare members are entitled to on-site interpreter services during medical visits. Language interpreter services are provided for non-English speaking members. Sign language services are covered benefits for members who are hearing impaired. These services are not available in an inpatient hospital or surgical-center setting. We have contracted vendors who provide on-site language and sign language interpreters. If your BlueCHiP for Medicare patient needs interpreter services, call the Physician and Provider Service Center at (401) 274-4848 to make arrangements. Advance notification is required. Language interpreter requests must be made 72 hours prior to the date of service. Sign language services must be requested three weeks in advance of the date of service.
- **Exclusive Laboratory Services** – All outpatient laboratory services must be performed at East Side Clinical Laboratory, Quest Diagnostics, Inc., Lifespan Laboratories, or Coastal Medical Laboratory to be covered. Certain lab services may be performed by physician's offices, hospitals, and/or urgent care centers that are BlueCHiP for Medicare network providers. An exceptions list is included in the BlueCHiP for Medicare Laboratory Network Exemption List Policy.
- **Durable Medical Equipment (DME) Provider(s)** – All covered DME must be ordered by a participating BlueCHiP for Medicare provider and should be obtained from a participating BlueCHiP for Medicare DME provider. You may use a network pharmacy for certain related supplies, such as glucose monitors, lancets, and test strips.
- **For all BlueCHiP for Medicare members with Medicare Part D prescription drug benefit (except Core members who do not have Part D prescription coverage)** – When using the Medicare Part D prescription drug benefit outside of the BlueCHiP for Medicare pharmacy network, the member may be responsible

for the difference in cost between what BlueCHiP Medicare would have paid at a network pharmacy and the actual retail cost of the medication.

All BlueCHiP for Medicare plans offer the following coverage. (Please note, this is not an all encompassing list. Please call BlueLine or visit BCBSRI.com for a complete listing of benefits covered under each BlueCHiP for Medicare plan.)

- Coverage for medically necessary inpatient services.
- Coverage for medical nutrition therapy, regardless of diagnosis.
- Coverage for smoking cessation counseling visits. Up to eight face-to-face visits per year are covered. Visits must be ordered by a participating provider and provided by a qualified physician or other Medicare-certified practitioner.
- Coverage for Standard and U.S. Food and Drug Administration (FDA)-approved human immunodeficiency virus (HIV) rapid screening tests.
- Coverage for one wellness visit, one annual physical exam, one routine hearing test, and one routine vision exam each year.
- Coverage for skilled nursing facility stays. (No prior hospital stay is required.)
- Coverage for Medicare-covered preventive services.
- Coverage up to \$350 per year toward the purchase of a wig(s) when the member has a diagnosis of cancer.

Out-of-Network Benefit Options

BlueCHiP for Medicare Core, Standard with Drugs, Plus, and Group Plus

Members' coverage for services received from out-of-network providers is limited to emergent or urgent care, renal dialysis, ambulance services, and care that has been pre-approved by the plan or a plan-contracted partner to be received out of network.

BlueCHiP for Medicare Value, Preferred, Group Preferred, and Group Preferred Unlimited: Point-of-Service (POS) Benefit

Available to BlueCHiP for Medicare Value, Preferred, Group Preferred, and Group Preferred Unlimited members only.

The POS option is an additional benefit that gives BlueCHiP for Medicare Value, Preferred, Group Preferred and Group Preferred Unlimited members the ability to receive specified covered services outside of the plan's provider network for additional costs. If the provider does not accept Medicare assignment, the member will be liable for coinsurance up to 35% of the Medicare allowable amount. Members are encouraged to check with their providers before using this benefit.

Plan prior authorization rules apply to the POS benefit. If prior authorization is required on a service that is performed in the network, the same service requires prior

authorization if received outside the network through the POS benefit. If prior authorization is not received, the service will not be covered.

- **Member costs**
 - ***If the provider accepts Medicare assignment*** (accepts Medicare level of reimbursement, including the required 20% member coinsurance as payment in full for covered services), then the member will be liable for 20% of the Medicare allowable amount for the service.
 - ***If the provider does not accept Medicare assignment***, the member will be liable for coinsurance up to 35% of the Medicare allowable amount. Before receiving services out of network, the member should ask whether their provider accepts Medicare assignment as this will lower their out-of-pocket expense.
- **POS Out-of-pocket Maximum**
 - ***For Value Plan Members – \$4,450 point-of-service (POS) out-of-pocket maximum (may change each calendar year)***. This is the most a Value Plan member will pay for coinsurance for POS-covered services for the calendar year. Once the member reaches the \$4,450 amount, he or she is no longer responsible for applicable coinsurance for POS-covered services during the calendar year.
 - ***For Preferred Plan Members – \$3,000 point-of-service (POS) out-of-pocket maximum (may change each calendar year)***. This is the most Preferred Plan members will pay for coinsurance for POS-covered services for the calendar year. Once the member reaches the \$3,000 amount, he or she is no longer responsible for applicable coinsurance for POS-covered services during the calendar year.
- **POS Limitations (May change each calendar year.)**
 - While in the plan's service area, POS members must use BlueCHiP for Medicare-contracted laboratories and durable medical equipment providers. There is no POS benefit within the service area for these services.
 - There is no POS benefit for health club memberships, pharmacies, inpatient behavioral health services*, inpatient substance abuse services*, and behavioral health partial hospitalization*.

*As a result of Mental Health Parity, inpatient behavioral health services, inpatient substance abuse services, and behavioral health partial hospitalization are covered out of network through the POS benefit for BlueCHiP for Medicare Group Preferred and Group Preferred Unlimited only.

Additional Benefits on Certain BlueCHiP for Medicare Plans in 2014

(Benefits may change annually. Providers will be notified of any changes at least 60 days prior to the changes being effective. This notification will be sent out via Provider Update.)

- *BlueCHiP for Medicare Group Plus, Group Preferred, and Group Preferred Unlimited members are covered for certain preventive dental services.*
- *BlueCHiP for Medicare Group Preferred and Group Preferred Unlimited members are covered for certain comprehensive dental benefits and receive a \$1,500 dental maximum per calendar year for covered dental services.*
- *Allowance toward the purchase of vision hardware. Use of plan-contracted providers is not required:*
 - *Standard with Drugs and Core – \$100/year*
 - *Plus and Preferred – \$150/year*
 - *Group Plus, Group Preferred, and Group Preferred Unlimited – \$70/year*
- *BlueCHiP for Medicare Preferred, Group Preferred, and Group Preferred Unlimited members receive \$500 every three years toward the purchase of a hearing aid. This is a combined total for both ears. Use of plan-contracted providers is not required.*

Coordination/Non-Duplication of Benefits

Individuals enrolled in BCBSRI health plans may have additional coverage through their spouses or parents. Standardized industry-wide rules have been established for determining the order of financial responsibility when multiple plans cover the same services. BCBSRI is responsible for coordinating the appropriate payment of benefits for our members, and we adhere to industry rules and guidelines in doing so.

As a BCBSRI physician/provider, you are required to:

- Provide any information necessary for collection and coordination of benefits (COB) when a member has other health insurance coverage.
- Comply with BCBSRI's COB and duplicate coverage provisions.
- Assign to BCBSRI all payments owed by, or received from, another payer for services you have rendered to BCBSRI members.

Role of the Physician's Office

The physician's/provider's office is not responsible for determining the order of benefit payment from the multiple health plans of a patient, or coordinating the order of payment. We assume full responsibility for COB activities.

We do, however, require the office's cooperation as we work to accomplish COB. We need the office to supply us with requested information and abide by our COB rules. To determine whether a member has other coverage, the office should ask the member when

he/she first comes in for an appointment. The information should be updated at least once a year or, preferably, at every service date.

Whenever authorization for services is recommended, we will make an initial assessment as to whether BCBSRI is the primary insurer.

The following brief overview of the basic COB rules may help offices determine payment priority and streamline their own bookkeeping and billing efforts. When more than two plans are involved, or when there are complex relationships among employee-subscribers and multiple dependents, the rules can become quite complicated; in these instances it is helpful to contact all involved carriers before submitting claims.

Coordination of Benefits

When members are covered by more than one insurer, their BCBSRI benefits are coordinated with those of the other insurer(s), so that the total amount paid does not exceed the cost of those services.

Plan 65 is a Medicare supplement. Providers should bill Medicare as primary, BCBSRI is the secondary payor. Plan 65 members enrolling into a Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD) plan are advised by the MA organization they should terminate their supplemental coverage once their coverage in the MA or MA-PD is confirmed by Medicare. MA or MA-PD members should not enroll into a supplemental plan.

Note: If a member has a Medicare Advantage plan and a Medigap policy (Plan 65 supplement), the Medigap policy will not work. This means it will not pay any deductibles, copayments, or other cost-sharing under the member's Medigap policy.

Members' BCBSRI benefits will be coordinated with any benefits they may receive from these types of coverage:

1. Another (or more than one) group health plan available to the member through an employer or association.
2. Medicare, Medicaid, or other government-funded health programs, including their alternatives, such as an MA plan offered by another carrier. Medicaid is always the payer of last resort.
3. TRICARE for dependents of military personnel, or CHAMPVA for dependents of military veterans.

Procedures

1. Collect applicable copayments, coinsurances and/or deductibles.

These amounts are collected the same way regardless of whether BCBSRI is the primary or secondary payer. (See page 121.)

2. Submit the claim for services to BCBSRI.

When submitting the claim, be sure to identify any additional coverage the member may have.

If you can identify BCBSRI as the secondary carrier, you may postpone submitting the claim until the other carrier has paid benefits, as long as the claim will be submitted to BCBSRI within the timely filing requirements. In this case, please submit a copy of the other carrier's benefit payment explanation with your claim.

If BCBSRI is clearly the primary carrier, bill the other carrier after receiving our Remittance Advice (RA/Settlement) form.

If you cannot identify which plan is primary, call the Physician and Provider Service Center for assistance.

Workers' Compensation and Other Third-Party Liability

BCBSRI is not responsible for expenses related to injuries sustained on the job or due to the actions of a third party. When a claim is the result of a work-related injury, you must identify this on the claim. When such expenses have been covered by a BCBSRI plan, we will immediately pursue recovery of the paid amount.

Subrogation and Other Third-Party Liability

If a member sustains injuries for which someone else is responsible, BCBSRI has a right of subrogation and will pursue recovery of expenses related to the member's care and treatment of those injuries. Other party liability may be managed by a third-party carrier, such as auto, homeowner's, personal, or business liability coverage held by the person responsible. When a claim is the result of an accident or injury, you must identify this on the claim.

Note: If the patient is a member of BCBSRI, a claim for a service(s) should only be submitted to BCBSRI. A claim for a service(s) should not be submitted simultaneously to a carrier other than BCBSRI.

BCBSRI automatically has a lien to the extent of benefits provided by the member's plan against any recovery a member receives from a third party or its agent, such as an

insurance policy or from an uninsured/underinsured settlement. This lien will be pursued whether the recovery is by settlement, judgment, or other means.

Procedures

1. Provide needed medical care to a member who becomes ill or sustains an injury in connection with the performance of his/her job, or as the result of the actions of a third party.

You should identify any illness or injury that may be covered under workers' compensation laws or other legal remedies, and help members understand the responsibility of others to pay for medical care resulting from their (the other party's) actions.

IMPORTANT NOTE: If you know for certain that a workers' compensation claim has been or will be accepted by a member's employer, we advise that you not provide non-emergency treatment to that member unless you have been approved by the employer's worker's compensation carrier to treat the work-related condition. It is customary for an employer to not cover charges from providers who have not been approved by their workers' compensation carrier. In an emergency, you may proceed with treatment as though workers' compensation were not a consideration.

2. Collect applicable copayments, coinsurances, and/or deductibles.

These amounts are collected the same way regardless of whether BCBSRI is the primary or secondary payer.

3. Submit the claim for services to BCBSRI.

If the patient is a member of BCBSRI, a claim for a service(s) should only be submitted to BCBSRI. A claim for any service(s) should not be submitted simultaneously to a carrier other than BCBSRI.

When submitting a claim, please include all information that could help us identify any other parties that may bear financial liability for the member's condition.

Claims Submission and Payment

Claims may be filed either electronically or on paper. For electronic claims submission, see Chapter 9. For paper claims submissions, use a CMS-1500 form.

A claim must be submitted for all services not included in a capitation compensation arrangement. Claims for non-capitated services provided by personal physicians will be considered for payment of allowable fees and accumulation of utilization data related to ambulatory services.

When the rendered services are included in a personal physician's capitation arrangement, a data-only claim is submitted. These claims are called encounter claims. All mandatory elements on a CMS-1500 form must be completed for encounters, including box 10A, which identifies work-relatedness.

Encounter data helps us evaluate network and physician-specific utilization of ambulatory services, and is an important aspect of our quality improvement program. All claims must be submitted within 180 days of the date of service.

Services Requiring Claims Submission

The following are examples of typical professional services that require claims submission:

- All office evaluation/management services, including new and established patient office visits, new and established patient preventive visits, and office consultations
- Surgical services
- Hospital visits and inpatient consultations
- Lab work, X-rays, and EKGs

Required Information

To ensure prompt payment, complete all mandatory fields on the claim form including, but not limited to:

- Personal information that identifies the member as a subscriber or dependent of a subscriber, and other pertinent data
- Coverage information, including the member's specific plan; coverage from other carriers; and any information that can help identify whether another party is financially liable for the charges
- Identifying rendering physician/provider information
- Identifying referral physician/provider information, if appropriate
- Charge of the service
- Patient treatment information, including diagnosis, CPT[®], or HCPCS[®] code for the service and any applicable modifier(s), date services were rendered, and service site
- Tax identification number (TIN)
- The member's three-letter alpha prefix

When the required information is not included, the claim will be denied. A new claim with correct and complete information must be submitted in order for a denied claim to be reconsidered. The Claims Adjustment Request Form, to be completed and submitted with a corrected claim, is available in the Provider section of BCBSRI.com and in the Appendix of this manual.

Clean Claims Defined

A claim for payment of healthcare services that is submitted via acceptable claim forms or electronic formats with all required fields completed with accurate and complete information in accordance with BCBSRI's requirements.

A claim is considered “clean” if the following conditions are met:

1. The services must be eligible, provided by an eligible provider, and provided to a person covered by the insurer.
2. The claim has no material defect or impropriety, including, but not limited to any lack of required substantiating documentation or incorrect coding.
3. There is no dispute regarding the amount claimed.
4. The payer has no reason to believe that the claim was submitted fraudulently or there is no material misrepresentation.
5. The claim does not require special treatment or review that would prevent the timely payment of the claim.
6. The claim does not require coordination of benefits, subrogation, or other third party liability.
7. Services must be incurred during a time where the premium is not delinquent. (This condition does not apply to BlueCHiP for Medicare members.)

If you have questions about whether or not your claims meet all conditions of a “clean claim,” you may contact the Physician and Provider Service Center for more information.

Procedures

1. Complete a CMS-1500 claim form.

2. Submit the form to BCBSRI.

To be considered for benefit payment, you must submit a clean claim within 180 days of the date of service or completion of an inpatient stay, or monthly in the case of an extended stay. Although not submitted for payment purposes, encounter claims must also be received within the same time frame. Claims submitted after the time limit will be denied. Please remember that in accordance with your participating physician/provider agreement, you may not “balance bill” patients for services that were denied because you did not meet timely filing requirements.

Allowable Fees

Physicians/providers are required to accept as payment in full the amount allowed by BCBSRI for covered services less any applicable copayment or coinsurance collected from the member at the time of service. Disputed payments will be reconsidered upon request. This includes any claims for members of another Blue Plan.

Physicians/Providers

BCBSRI fee-for-service reimbursement will not exceed the maximum allowable. Exceptions may be allowed when the service or procedure is complex and warrants individual consideration.

- **BCBSRI Plans** – Compensation for services is limited to the BCBSRI schedule of allowable fees. This schedule assigns a dollar equivalent for services identified in the most recent Physician's Current Procedural Terminology (CPT[®]) coding system, supplemented by other codes we use for administration of other benefits.

The fee schedule is periodically reviewed. If we alter the schedule in any way, you will be notified 60 days prior to the effective date of the change. (*This notification will be sent out via Provider Update.*) Services rendered after the effective date will be reimbursed according to the revised schedule. Services rendered prior to the effective date but submitted for payment afterward will be compensated according to the schedule in effect at the time of service.

- **BlueCHiP for Medicare** – Services are reimbursed according to the Rhode Island BlueCHiP for Medicare fee schedule in effect when the member receives care.
- **Plan 65** – BCBSRI will pay the plan-appropriate percentage of the Medicare allowable charge.

Payment Forms and Claims Checks

A Remittance Advice (RA/Settlement) form is sent to each physician/provider for all claims processed within a processing period, accompanied by a check for the total amount payable for those claims.

BCBSRI's standard for claims payment is within 30 days of receiving a clean electronic claim form and 40 days of receiving a clean paper claim form. Settlements are produced weekly for electronic submitters and every two weeks for physicians/providers submitting paper claims.

Payment Errors

BCBSRI has the right to recover from physicians/providers any payments made in error. In turn, physicians/providers have the right to have payment determinations reconsidered and adjustments made when appropriate.

We routinely conduct random retrospective audits of claims payments. We look for errors that physicians/providers may have made on claim forms, or errors made by BCBSRI in verifying authorizations, claim system data entry, or payment processing.

If BCBSRI has, in error, over-compensated a physician/provider for services rendered, we have the right to recover the overpayment amount by offsetting against future settlements.

If a retrospective audit reveals that BCBSRI has not compensated a physician/provider in full for services rendered, a payment adjustment will be made automatically. If you have received payment from the member and we later reimburse you for the service, you must reimburse the member what he or she paid.

Overpayment recoveries and underpayment adjustments will be itemized on the physician's/provider's next settlement. All over/underpayment adjustments are reflected in the physician's/provider's annual utilization and compensation experience.

Appeals of Payment Determinations

You are entitled to a review and reconsideration of any claims payment that you believe is inaccurate or does not reflect an appropriate allowance for the services rendered. Administrative appeals are handled by BCBSRI's Grievances and Appeals Unit (GAU). GAU will acknowledge receipt of your appeal either orally via telephone or in writing via an acknowledgement letter. Our staff will complete the review and send you a determination letter. The entire process will be completed within 60 calendar days of our receipt of your appeal.

To report errors or request review of a payment (or adjustment), call the Physician and Provider Service Center, or write to or send the Provider Appeal Request Form (see the Appendix) to:

Attn: Grievances and Appeals Unit
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903

CHAPTER 8

QUALITY MANAGEMENT AND IMPROVEMENT

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QUALITY MANAGEMENT AND IMPROVEMENT

Quality Management Program Overview

BCBSRI's quality management (QM) program, based on an annual evaluation of the needs of our members, helps us to implement activities that will improve their overall quality of care and service. The QM program must provide proof that:

- Activities and initiatives are developed to meet stated objectives;
- Plan performance is evaluated against stated objectives; and
- Outcomes are analyzed to determine the effectiveness of implemented actions.

In order to withstand public scrutiny of the quality of care and service our members receive, our QM program needs the full support, cooperation, and endorsement of our physicians/providers. We must be able to demonstrate in measurable and objective terms that you share our commitment to ensuring the delivery of safe, appropriate, and effective healthcare services to our members. As such, section 3.5 of the BCBSRI Administrative Policies (Exhibit A) of the Physician/Provider Agreement details the obligation of participating physicians, providers, clinicians, and their office staff to cooperate and participate, as required, in all aspects of peer and quality review programs as may be established by BCBSRI. Please see the Agreement for complete information. Participating physicians, providers, and facilities are also required to permit BCBSRI to use performance data for health plan operations in all product lines.

Basis of the Program

BCBSRI has developed a structured and well-defined QM program. Its objective, systematic evaluation of members' care addresses the following issues:

- The system structure
- Access to care and service
- Improvements in administrative and clinical processes used to deliver care
- Mechanisms for identifying and resolving quality-of-care concerns
- Mechanisms for ensuring that network providers meet standards and requirements set forth by state and federal agencies and accrediting organizations

Purpose and Philosophy

The QM Program exists to ensure that our members experience optimal health outcomes across the continuum of healthcare, including physical and behavioral health. Utilizing a continuous quality improvement process, the QM Program establishes high standards of evidence-based clinical practice in the community, prioritizes member health and safety, and works to improve member and provider satisfaction. This process serves to optimize members' health and services and to positively impact the health of our community.

Goals and Objectives

The overall BCBSRI quality management program goals are to:

- a) Perform quality improvement and assurance activities in alignment with corporate goals, missions, and strategies.
- b) Develop and maintain a QM structure that links cross-functional expertise and programming to promote organizational, member, and provider success.
- c) Optimize the delivery of an integrated medical and behavioral health system.
- d) Improve the cost, quality, and efficiency of service delivered to members and providers.
- e) Continuously monitor and evaluate best clinical practice standards and enhanced system processes to identify new opportunities for improving upon engagements with members and providers.
- f) Improve the quality and coordination of care across the healthcare continuum of medical and behavioral health.
- g) Improve the quality of member and provider engagement and satisfaction with the health plan.
- h) Identify the spectrum of cultural and linguistic needs of our membership to offer a diverse array of services that provide meaningfully improved care to our members and supports our providers' care for members.
- i) Promote safe evidence-based clinical practice across our network of medical and behavioral health providers.
- j) Encourage and inform our members to help them make healthy lifestyle choices that promote primary prevention and self-management of chronic and complex conditions.
- k) Collaborate with community partners to achieve improved medical and behavioral health for all BCBSRI members.
- l) Utilize valid and reliable clinical quality and performance data to credential and re-credential medical and behavioral health providers.

Program Description and Evaluation

A detailed QM Program Description is reviewed and updated annually to reflect the objectives of the QM program and its related activities. There is an annual QM Workplan that outlines all of the QM activities to be pursued over the coming year, which is also updated and reviewed.

In addition, BCBSRI produces an annual QM Program Evaluation. This report includes a summary of progress in meeting program goals and highlights the results of our clinical, preventive, and service activities. You can read and/or download this report as well as the annual QM Program objectives at BCBSRI.com/planinfo.

Program Authority and Responsibility

A governing body oversees all aspects of the program to ensure its relevance and effectiveness in achieving its stated objectives.

Board of Directors

The BCBSRI Board of Directors (BOD) approves the QM Program Description and Plan annually. The BOD has formally delegated the development and oversight of the QM Program to the Executive Quality Council (EQC).

Oversight for implementing the QM Program is shared by the EQC and its subcommittees, the Chief Medical Officer, and the Director of Quality Management. While these individuals have primary responsibility for implementing the QM program, all BCBSRI staff is responsible for ensuring the implementation of certain elements of the QM program.

The QM Work Plan is developed annually by the Director of Quality Management or designee, in collaboration with the Chief Medical Officer, the Managing Director of Behavioral Health & Clinical Quality Strategy, management staff (as appropriate), and the EQC.

Executive Quality Council (EQC)

Purpose and Objectives

The purpose and objectives of the EQC are to:

- To assure the quality of healthcare provided to BCBSRI members meets or exceeds medical and behavioral health community standards for evidence-based best practices
- To assure administrative services are delivered so as to promote member and provider satisfaction and meet or exceed performance targets
- To provide direction and monitor transformation of the delivery system in support of the quality management goals
- To provide direction and monitor the implementation of all quality management activities
- To provide direction and monitor implementation of utilization management (UM) activities
- To provide direction and remove organizational barriers to the implementation of interventions that promote improvements in member and provider experience
- To serve as the Executive Steering Committee of the company's Centers for Medicare & Medicaid Services 5 STAR strategy and activities

Responsibilities and Functions

The committee's responsibilities/functions include but are not limited to:

- Fulfill responsibilities for implementation of the QM Program, as delegated by the BOD.
- Review and approve the QM Program Description, QM Work Plan, and Annual QM Program Evaluation (which includes the UM Program Evaluation), and related policies and procedures (P&Ps) as approved by Quality and Regulatory Monitoring.
- Review and approve the clinical and service priorities for the year.
- Provide guidance to the scope of clinical studies, preventive health studies, health management programs, and focused audits.
- Evaluate clinical care, and promote the goals that all care provided by all physicians and providers is high quality, appropriate, timely, safe, and consistent with BCBSRI guidelines and community standards through ongoing QM activities such as sentinel events monitoring, medical and behavioral health care evaluation, and member and provider satisfaction data.
- Review activities of all subcommittees, and make recommendations and take action, as appropriate.
- Review patient safety issues.
- Review the performance of delegated vendors and make recommendations for next steps when appropriate.

Support Committees

The EQC is supported by a number of subcommittees established as formal avenues of two-way communication. These committees are comprised of internal representatives from BCBSRI functional departments and external representatives from the provider network. For information on committee activities, you may contact BCBSRI's Managing Director of Clinical Affairs or your Provider Relations Representative.

Physician/Provider Credentials Committee

The Credentials Committee membership includes:

- BCBSRI Medical Director
- Manager of Databases & Credentialing
- BCBSRI physician reviewers
- A minimum of seven community-based providers, including primary care and specialist providers, contracted network dentists, and behavioral health professionals
- Executive Director of Blue Cross Dental
- Quality Management (QM) representative

- Representatives from the Credentialing Department and other individuals (staff, individuals involved in delegated arrangements and others) are invited to attend committee meetings as determined by the Physician/Provider Credentials Committee

Purpose and Objectives

The purpose and objectives of the Physician/Provider Credentials Committee are to:

- To ensure providers (physicians, allied health providers, dentists, behavioral health specialists) wishing to participate in the BCBSRI provider network meet credentialing requirements as set forth in the Credentialing Policies and Procedures
- To review credentials and practice patterns for contracted providers during the recredentialing process and, when appropriate, recommend to the Professional Advisory Committee the implementation or continuation of a corrective action, suspension, or termination of a contracted provider in accordance with policies and procedures
- To ensure health delivery organizations (HDOs) wishing to participate in the BCBSRI network meet contracting requirements, including a quality assessment, as set forth in BCBSRI's P&Ps

Responsibilities and Functions

The Physician/Provider Credentials Committee ensures all providers, credentialed or re-credentialed, meet credentialing requirements as outlined in the Credentialing P&Ps. The committee is responsible for:

- Review of completed credentialing or re-credentialing applications with questionable findings.
- Review patterns of professional liability cases as it relates to current qualifications, actions against professional licenses, or restrictions to a physician's practice.
- Review of information from quality improvement activities, which may include results of medical record and facility site reviews, utilization data, physician profiles for clinical and preventive health and quality of care complaints.
- Approval or denial of credentialing applications and approval of re-credentialing applications, and recommendations to PAC whether to implement or continue with corrective action plans, suspension, or termination during re-credentialing.
- Approval or denial of health delivery organization applications and recommendations to PAC regarding the implementation and continuation of corrective action plans, or recommendation to the Senior Vice President, Network Management to terminate.

The Board-designated Fair Hearing Committee retains the right to overturn an adverse decision that has been made by the PAC.

The Professional Advisory Committee (PAC)

Purpose and Objectives

The purpose and objectives of the PAC are to:

- Oversee the design and follow through of clinical and preventive health monitoring and evaluation activities/studies and medical care standards (including preventive healthcare guidelines)
- Review appropriate policies and procedures.
- Review care that is of potentially substandard quality or presents patterns of inappropriate utilization.
- Review disciplinary or sanction information from licensure authorities and, when necessary, approve corrective action plans for individual providers.
- Initiate provider disciplinary actions, up to and including termination.

Responsibilities and Functions

The committee's responsibilities include, but are not limited to:

- Review and approve clinical and preventive health practice guidelines or standards of care,
- Review, recommend, and, when appropriate, assist in the design of clinical and preventive health studies.
- Recommend to the EQC the priorities for monitoring and evaluation of clinical activities and of administrative functions that support clinical care.
- Act on the decisions of the EQC on prioritization and the scope of the clinical monitoring and evaluation activities.
- Oversee the review of cases that are referred through the QM Department indicative of potential medical and behavioral health quality of care concerns.
- Formulate corrective action plans for individual providers, as necessary.
- Make determinations regarding termination or limitation of clinical privileges of individual providers.
- Recommend system/process improvements for the EQC.
- Review reports of disciplinary actions by licensure authorities.

Behavioral Health Committee (BHC)

Purpose and Objectives

The purpose of the BHC is to build an effective organizational structure that supports and ensures that behavioral health strategic objectives and goals are met. The committee will ensure that the behavioral health strategy continues to drive an integrated behavioral health and medical model incorporating products, wellness, and mental health and substance abuse.

Responsibilities and Functions

The committee's responsibilities include, but are not limited to:

- Review policy related to behavioral health continuous monitoring of internal and external performance metrics.
- Review strategies to improve member and provider satisfaction and engagement, 5-Star, and NCQA performance.
- Review strategies and programming to ensure appropriate utilization and efficiency.
- Demonstrate superior behavioral health performance and integration of behavioral and medical health services to minimize carving out of behavioral health benefits and maximize BCBSRI delivery of both services.
- Ensure BCBSRI and the delegate are providing high-quality programming and initiatives.
- Maintain and build upon a collaborative relationship with behavioral health vendor.

Pharmacy and Therapeutics Committee (P&T)

Purpose and Objectives

The P&T Committee oversees the creation of medication usage policies and promotes clinically appropriate safe and effective pharmacotherapy for the corporation on plan members for both medical and behavioral health treatment

Responsibilities and Functions

Responsibilities include, but are not limited to:

- Serve in an evaluative, educational, and advisory capacity to BCBSRI.
- Develop, maintain, and promote a formulary system based on appropriate rationale and cost-effective care, including the approval of prior authorization, step, and quantity limit program rules.
- Establish programs and procedures that promote safe, effective, and affordable drug therapy for patients, including the review of utilization criteria and quantity limits.
- Review the results of Drug Usage Evaluation (DUE)/Drug Utilization Review (DUR) and make recommendations to promote appropriate drug use.
- Recommend and/or assist in the formulation of educational programs to provide complete and/or current knowledge on matters related to pharmaceuticals and drug use.
- Review and approve practice guidelines, as needed for efficacious pharmacotherapy.
- Monitor appropriateness of usage of pharmacologic agents (under/overutilization and coordination of care).

- Oversee the activities of the Specialty Pharmacy and Therapeutics Committee, integrating them into the larger pharmacy management activities.

Clinical Quality Oversight Committee (CQOC)

Purpose and Objectives

The CQOC reviews plan-wide data and HEDIS Survey and Effectiveness of Care results to recommend the clinical and service project priorities for the health plan for the year. It provides insight and analysis in the development and implementation of programs and interventions to improve clinical and service performance that align with plan-wide objectives.

Responsibilities and Functions

The committee's responsibilities include, but are not limited to:

- Provide prioritization, oversight, and guidance to initiatives designed to improve the health and clinical outcomes of membership.
- Ensure clinical programs address the spectrum of health, including preventative health, medical health, behavioral health, and the integration thereof.
- Prioritize the creation and utilization of reliable metrics to provide baselines, set goals, monitor performance, identify barriers, and inform next steps for clinical initiatives.
- Utilize HEDIS, HOS, 5-Star, and plan-wide data to identify opportunities for clinical improvement and to develop interventions.
- Utilize clinical evidence, best practice data, and industry standards to inform CQOC reviews and recommendations.
- Provide awareness of community clinical and preventive health initiatives to enhance collaboration with member communities and to optimize resources.
- Assess feasibility of intervention designs to achieve desired clinical outcomes.
- Provide consultation service for clinical and preventive health activities conducted by another organization on the behalf of BCBSRI under delegation agreement when appropriate.
- Annually review the population assessment that drives clinical program development in Case Management, Disease Management, and Population Health.
- Annually review clinical programs, report on satisfaction with clinical programs, and report on program effectiveness to ensure that opportunities for enhancement of programs are identified and implemented.
- Ensure CQOC member composition meets the needs of the Committee on an ongoing basis.

BCBSRI Customer Experience Committee

Purpose and Objectives

The BCBSRI Customer Experience Committee is a cross-functional team that aggregates and analyzes data collected from customers via a variety of sources (CAHPS, Member Experience survey, etc.). This team reviews the data and analyses in order to identify and prioritize solutions to customer pain points. Objectives of the Committee are to improve:

- Overall health plan rating
- Customers' ability to access care quickly as well as their perception of doing so
- Customers' satisfaction with their experience with their health plan and their health care providers

Responsibilities and Functions

The committee's responsibilities include but are not limited to:

- Leveraging CAHPS and other experience survey results, findings, and data as well as complaints, grievances, and other customer analyses, to identify, prioritize, and implement solutions that support and improve key areas of focus:
 - Access to care
 - Getting care quickly
 - Experience with their healthcare providers
 - Experience with the health plan
 - Plan understanding for current and prospective customers

Program Data

The data used to construct and evaluate QM programs are derived from various operational activities connected to the actual delivery of healthcare services to BCBSRI members as well as the results of QM programs designed to provide measurable data.

Internal Sources

These sources include:

- **Quality and Provider Services**
Medical records, focused studies, quality issues, logs and reports, member complaints/appeals, provider office/facility site assessments (including health delivery organizations), physician peer review, adherence to internal policies and procedures, quality control processes
- **Health Analytics**
HEDIS[®] and Member Touchpoint Measurement (MTM) reports, data and reports related to clinical and service studies/activities, member and provider satisfaction surveys, disenrollment rate
- **Health Management and Integration**

Encounter/claims data, utilization data, focused diagnosis/treatment audits, care coordination, and disease management and primary prevention

- **Customer Service**
PCP change requests, voluntary terminations, and telephone contacts
- **Contracting Services**
Credentialing, recredentialing, GeoAccess monitoring, and directory production

External Sources

These sources include:

- Member satisfaction surveys
- Member access surveys
- Regulatory and accreditation reviews
- Provider/office manager satisfaction surveys
- Medical records
- Delegated reports, as applicable

Program Standards/Criteria

Prior to implementing any particular activity, BCBSRI establishes the standards and criteria against which network performance is evaluated. We target both process and outcome, and base these criteria on a combination of professional and industry-recognized standards as well as modified industry standards. Network-wide results are compared against benchmarks established by national healthcare organizations as adapted for local applicability.

These standards and criteria may be applied prospectively, concurrently, and retrospectively, as appropriate. Multiple data collection periods are tracked and analyzed to discern trends in compliance with the standards/criteria and effectiveness of the program.

BCBSRI QM program standards address:

- Procedural evidence that defined standards are being met
- Clinical practice guidelines/standards, including behavioral health
- Preventive health guidelines
- Health education and wellness (e.g., lifestyle issues, use of the delivery system)
- Access to/availability of covered services, such as geographical availability and time to schedule appointments
- Medical record documentation
- Member service
- Complaints and appeals
- Credentialing/recredentialing
- Facilities

- Over- and under-utilization
- Disenrollments, PCP change, and selection standards
- Continuity and coordination of care standards
- Claims standards

The QM program includes a peer review process for judging network-wide performance against the program's standards and criteria as well as identifying individual providers for potential outlier behaviors and/or providing counseling to improve awareness and performance in critical areas.

Quality Indicators

BCBSRI selects indicators based on their common applicability to our member population, as defined by health data information obtained in the following categories:

- Primary care and high-volume specialty
- High risk
- Inpatient and ambulatory environments
- High cost
- Chronic illness
- Appropriateness of care
- Continuity and coordination of care
- Administrative/service
- Access and availability
- Member and provider satisfaction
- Behavioral health environments

Clinical indicators are developed and monitored by the Professional Advisory Committee. Services and administrative indicators are developed by individual departments and the Executive Quality Council.

Current Quality Improvement (QI) Activities

An effective QM program is an ongoing multifaceted process of improvement performance goal-setting, benchmarking for comparison measurement, outcome evaluation, problem identification, and improvement activity implementation.

BCBSRI's annual QI activities, targeting both network and internal areas of performance, are designed to affect improvements within a reasonable period of time. Initial activities focus on identified opportunities for improvement. We inform you of the measurements by which network-wide and/or individual performance are evaluated, and give you the

opportunity for feedback. Some outcomes are provided to you while others are available on request.

Communicating QI Activities

We provide feedback to all network physicians and providers to help reinforce positive practice patterns and indicate where performance does not meet standards/expectations. Our goal is to achieve better performance network-wide.

BCBSRI provides annual updates on our QI activities so that you are aware of recently achieved goals as well as those on which we continue to work. These updates are posted on BCBSRI.com.

If you have any concerns, comments, or suggestions regarding our QI activities, please contact BCBSRI's Managing Director of Clinical Affairs, Provider Services, or your Provider Relations Representative.

Credentialing

Providing member access to a network of qualified physicians/providers is the foundation of our QM program. We conduct site visits for initial credentialing and ongoing monitoring activity for primary care practitioners (not part of a PCMH), including pediatricians, internists, and family practitioners as well as OB-GYNs.

This process involves obtaining and verifying each applicant's credentials, and investigating any areas of potential concern. It includes a review of the physician's/provider's practice site(s) for conformance with office administration, physical access, and safety requirements.

Clinical Processes

This review involves a series of evaluations to determine how medical care and procedures are administered. Technical processes are evaluated to determine whether appropriate steps were taken to evaluate and treat specific symptoms and illnesses. Also, adherence to recommended practice guidelines/protocols is monitored.

Data derived from processed claims, ambulatory encounters, medical record reviews (including HEDIS[®] measures), and QM studies help identify additional opportunities for improvement. Identified problem areas will be targeted by an intervention designed to correct deficiencies and/or improve overall performance.

Study selections are based upon the characteristics of the BCBSRI member population, and several clinical outcome studies are conducted each year.

In addition to our health management programs, we monitor activities in these areas:

Administrative/Service Studies

- Member satisfaction
- Physician/provider satisfaction
- Access studies/monitoring
- GeoAccess (network availability) studies/monitoring
- Coordination of care (personal physician/referral/specialist communications)
- Coordination of care (personal physician/behavioral health)

Clinical Studies

- Comprehensive diabetes care
- Beta-blocker after heart attack
- Follow-up after mental health hospitalization
- Antidepressant medication
- Follow-up after substance abuse hospitalization
- Asthma
- Congestive heart failure

Preventive Health Studies

- Mammography screening
- Cervical cancer screening
- Well child/EPSTD
- Cholesterol management
- Smoking cessation counseling
- Immunization rates (child and adult)
- Prenatal care
- Chlamydia screening
- Controlling high blood pressure
- Colorectal screening

When necessary, onsite audits of patient records are used to collect source data. Results are compiled to determine network performance norms and compare with community, regional, and national norms.

Every effort is made to cooperate with physicians/providers offices when scheduling onsite audits. We provide as much advance notice as possible, and only qualified personnel conduct the audits. (A staff member must be present.) The QI coordinator asks to see only the files of BCBSRI patients, and identifies these before the audit takes place.

Exit conferences take place with the staff or the physician/provider. If you have any questions regarding case audits, please contact the Manager of Quality Management.

NOTE: Onsite audits are also performed when the Department of Health, the Department of Human Services, or the Centers for Medicare & Medicaid Services conduct their periodic reviews. Those reviews are independent of BCBSRI's QM studies, but any deficiencies identified in these reviews may be considered when evaluating individual physician/provider performance and identifying process problems. In addition, URAC is the accrediting body for Case Management and conducts reviews every three years.

Patient Satisfaction

BCBSRI considers member satisfaction an important indicator of the quality of care and service delivered by both the network and the organization.

We assess member satisfaction using these data sources:

- Member satisfaction surveys
- Patient satisfaction surveys
- Member complaints and grievances
- Disenrollment studies
- Voluntary requests to change to another personal physician

We also monitor various indicators, such as telephone response time and call abandonment rates to help ensure member satisfaction with BCBSRI operations and Customer Service and identify opportunities for improvement.

Provider Satisfaction

BCBSRI is committed to establishing and maintaining mutually satisfactory relationships with its participating network physicians/providers. Satisfaction is measured every year through physician/provider satisfaction surveys and communications (both formal and informal) with Executive Quality Committee representatives, Physician/Provider Relations representatives, Health Management and Integration, Quality Consultants, and BCBSRI's Managing Director of Clinical Affairs.

We also monitor internal service indicators, such as:

- Referral and authorization turnaround times
- Authorization denial rates and related overturns
- Physician/provider administrative complaint/grievance and UM appeals resolution times
- Consistency of UM determinations

Quality of Care Complaints

BCBSRI's QM Department will review and investigate all issues regarding clinical quality of care. All potential quality of care issues are reported, tracked and evaluated by QM. The BCBSRI physician reviewer is responsible for making the final determinations. Appropriate practitioner interventions are implemented, as necessary.

All quality of care complaints are treated as confidential.

Definitions

A quality of care issue is defined as any issue that could adversely affect the health and well-being of the patient.

A potential quality issue is defined as a suspected deviation from expected provider performance, clinical care, or outcome of care, which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all potential issues represent quality of care issues.

A potential quality of care issue arises when a patient, patient representative or provider expresses verbal or written concern in any of the following areas:

- *Clinical issues* – Includes potential adverse outcomes of care, dissatisfaction with any aspect of delivery or non-delivery of healthcare,
- *Medical issues* – Includes incorrect diagnosis, failure to diagnose, inappropriate treatment.
- *Communication issues* – Includes uncooperative behavior or incomplete or inaccurate information
- *Documentation issues* – Includes incomplete progress notes

Investigation of a Potential Quality of Care Complaint

When the results of a quality improvement activity identify a physician/provider whose performance in any area does not conform to BCBSRI standards, we review the deficiencies in detail to determine whether a performance problem does exist. Whenever it is reasonable to expect that an improvement would elevate the physician's/provider's performance to that of his/her peers, we pursue corrective action.

BCBSRI has a system for monitoring practitioner adverse events every six months. An adverse event is an injury that occurs while a member is receiving healthcare services from a practitioner.

BCBSRI conducts monitoring activities to identify patterns or tendencies of all practitioners to repeat similar actions or behaviors resulting in quality of care complaints.

Mechanisms are in place to investigate practitioner-specific complaints from members upon receipt.

BCBSRI will evaluate both the specific complaint and the practitioner's history of issues. A trending report is produced that identifies the history of complaints for all practitioners every six months. If there are two occurrences of a quality of care complaint for any practitioner in a rolling six-month period, a summary is submitted to the Director of Quality Management and may be referred to the Professional Advisory Committee for discussion.

CHAPTER 9

ELECTRONIC SERVICES

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ELECTRONIC SERVICES

BCBSRI.com

As part of our ongoing commitment to streamline processes, improve efficiencies and strengthen communications, we want to ensure that we offer our providers a variety of tools and resources to quickly find up-to-date information regarding our healthcare plans, member eligibility, and current procedures and policies. BCBSRI.com is your one stop for a wide range of information critical to all aspects of your practice. Only registered providers and their staff can access much of the information available on BCBSRI.com.

To register, each provider will need a Personal Identification Number (PIN). To request a PIN or multiple PINs, please visit BCBSRI.com or contact the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050. Prior to being issued a PIN, you are required to complete and sign a Confidentiality and Security Guidelines form. This form is available on BCBSRI.com through the automated PIN request process. Upon receipt of the signed document, requested PINs will be sent to you via U.S. mail, or if requested, they can also be emailed to you. When you receive your PIN(s), you may elect to act as the System Administrator or you may wish to delegate this responsibility to a staff member. A System Administrator can create staff accounts, assign various levels of security for all accounts created, and manage/monitor created accounts. For multi-physician practices, the System Administrator can also add or remove providers from the website account.

Once registered, to access the Provider home page you'll need to sign in. Once signed in, you will have access to many features, including:

Account Access

- Provider Accounts
 - If you are part of a multi-physician practice, the System Administrator can add or remove providers from the website account for easy access.
- Staff Accounts
 - Create new accounts and manage existing staff accounts including assigning various security levels for each account created.

Provider Correspondence Center

Remittance Advices (RAs) are available 24 hours a day, seven days a week through the Provider Correspondence Center on BCBSRI.com. If you are not yet registered on BCBSRI.com, it is essential that you register today. *Providers will not be provided with paper copies of their RAs due to failure to register on BCBSRI.com.*

- **4 steps to get started** – Note: Only the system administrator (original creator) of the Web registration will initially have access to the Correspondence Center.
 1. When clicking on the Correspondence Center for the first time, the system administrator will be asked to establish the billing national provider ID (NPI). It is important that you register the NPI associated with your tax ID number (TIN).
 2. If you are a single practice and the rendering NPI is the same as the billing NPI, simply check the appropriate box and click Assign.
 3. If you have a separate billing NPI (type 2), then fill out the information in the Add a New Billing NPI section and click Add New.
 4. Once you have established the billing NPI, you will automatically be brought to the Search page. From there you can perform a basic search for RAs by completing the required fields, or conduct a more advanced search using one of the available search criteria.
- **How to assign Correspondence Center privileges** – If you would like to grant access to the Correspondence Center to other staff members who have access to BCBSRI.com, you will need to assign privileges. We also recommend that the system administrator designate someone in the practice to be a back-up administrator in the event the system administrator is unavailable or leaves the practice. (Note: You can only assign privileges after you have established the billing NPI.) To assign privileges:
 1. Go to Account Access and click Manage Staff Accounts. Find the staff member and click his or her name.
 2. You will be brought to a page where you can choose to assign privileges to the Correspondence Center. Check the box next to Correspondence Center. Be sure to also check any associated NPIs listed under the Correspondence Center.
 3. To assign a back-up administrator, check Manage Staff Accounts in the “Enable staff account management” box in step 2. This will allow the back-up administrator to assign privileges for other staff members as needed.
 4. The staff member will have access to the Correspondence Center the next time he or she logs in to BCBSRI.com.

We encourage you to start taking advantage of the convenience of using the Provider Correspondence Center today. Note: RAs for services rendered to Federal Employee Plan members will continue to be produced as paper RAs until further notice. Paper RAs will not be produced for services rendered to all other BCBSRI plan members.

Claims and Billing

This page includes claims and billing guidelines to assist you in submitting claims to BCBSRI.

Patient Profile

- Check Eligibility
 - Check eligibility and benefit information for up to 20 members at a time by member ID (including out-of-area members).
 - Check eligibility and benefits by member name/date of birth or Social Security Number (BCBSRI members only).
 - Check eligibility history by member ID or name search (BCBSRI members only).
- View Claim Status
 - Check the status of a claim submitted for payment. Please note that the provider must be logged in as the provider to whom the claim was paid.
- Preauthorization Requests
 - Submit and view the status of acute care or aftercare preauthorization requests and obtain authorization numbers. (After January 1, 2014, this will be moved into its own section and will be no longer be part of Patient Profile.)

Tools and Resources

Forms – BCBSRI.com has a variety of forms available to our providers and their staff. Downloadable forms include:

- Website Registration Instructions for Physicians/Providers
- Website Registration Instructions for Institutions/Facilities
- Behavioral Health Extension of Outpatient Benefits Form
- BlueCHiP for Healthy Options PCP Checklist – Adolescents
- BlueCHiP for Healthy Options PCP Checklist – Adult
- Care Coordination Referral Form
- Claims Adjustment Request
- CMS-1500 (08-05) Form Completion Informational Guide
- Coordination of Benefits Questionnaire
- Direct Deposit Agreement

- Email Address Update Form
- Instructions for Completing the Oral Enteral Food Products Reimbursement Form
- Modifier 22 – Unusual Procedural Services
- Offshore Subcontracting Questionnaire
- Oral Enteral Food Products Reimbursement Form
- Policy Request Form
- Practitioner Change Form
- Preauthorization Form for Oral Enteral Nutrition
- Primary Care/Behavioral Health Communication Form
- Primary Care Physician Selection Form
- Provider Appeal Request Form
- Referral Form
- Unlisted Code Claim Form for Durable Medical Equipment and Orthotics & Prosthetics Providers
- Unlisted Procedure Claim Form for Facilities
- Unlisted Procedure Claim Form for Physicians
- Voluntary Termination
- W9

Interactive forms:

- Request for Medicare Prescription Drug Coverage Determination
- Provider Application Request Form
- Provider Orientation Request Form
- Provider Policy Request Form

Surveys:

- Provider Relations Representative Visit Satisfaction Survey
- Physician/Provider Web Demonstration Satisfaction Survey

Publications – Reference our online publications for important information, reminders, policy changes, and updates on claims filing issues. At BCBSRI.com, you have online access to the following publications:

- *Provider Update*
- *Provider Manual*
- BlueCard Provider Manual
- Clinical Practice Guidelines
- Resource Guide for Work-Related Injuries
- Important Reference Information
 - o Provider Reference Tool
 - o 2013/2014 Influenza and Pneumococcal Immunizations

- o Specialty Pharmacy Preauthorization List
- o Most Commonly Used Modifiers Guide

Educational Materials – On this page, valuable resources are available for physicians/providers as well as patients/members, such as the Physician/Provider Orientation Presentation and the BlueCHiP for Medicare Educational Seminar Schedule.

Provider Tools – This page provides access to important tools and program information, such as the Radiology Management Program, CAQH Online Application, Provider Directory, and Patient Reviews of Provider.

Events

In this section, you can view a listing of and details for webinars and register for them.

News

A Provider News Box on the Provider home page highlights pertinent news affecting the provider community.

Health Insurance Portability and Accountability Act (HIPAA)

- Information, documents, and instructions regarding the HIPAA Transactions Regulation are also available on BCBSRI.com. Note: You do not need to log in to gain access to this area.
- In this section you will find:
 - Trading Partner Registration Form
 - Trading Partner Agreement (TPA)
 - BCBSRI 27x Realtime API Guide
 - Electronic Transaction Companion Guides
 - Provider Control Report Error Message Codes Guide
 - FAQs
 - 'How to Test' Documents
 - BCBSRI Blue Gateway SFTP Connection & Transmission Guide
 - BCBSRI Blue Gateway HTTPS Connection & Transmission Guide

Fee Schedules

Access the most current standard fee schedule for your specialty in a PDF format. You may use the Interactive Fee Schedule Request form when inquiring about 10 or more codes not on the standard fee schedule.

Secure Messaging

Send a question to, and receive a response from, Physician and Provider Service Center Representatives using a secure HIPAA-compliant electronic exchange of messages.

Secure messaging is a convenient online alternative to calling the Physician and Provider Service Center to get answers to your questions. You will receive a response to your question within one business day.

Contact Us

Refer to a listing of frequently called BCBSRI numbers. Featuring a “printer-friendly version,” this document is easy to view online or to print for quick reference.

FAQs

Frequently asked questions and answers are available on BCBSRI.com. There are four categories of FAQs: general questions and answers and those specific to the BlueCard and Radiology Management programs, as well as the new Facets system.

For more information regarding BCBSRI.com or to request an on-site orientation and overview of our website, please contact your Provider Relations representative to schedule an on-site visit.

Frequently Asked Questions about Confidentiality and Security

What is a personal identification number (PIN)?

A PIN is a randomly generated unique combination of letters and numbers, (usually six characters) assigned to a particular Provider Identification (ID) number that enables a provider to register on BCBSRI.com.

How do I obtain a PIN?

To request a PIN for your practice, please visit BCBSRI.com or contact the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050. In addition, the Confidentiality and Security Guidelines are mailed with the application packet to all new physicians/providers, and with the welcome packet to newly enrolled facilities.

Follow the instructions noted on the form and submit the signed copy back to BCBSRI. A form must be filled out for every Provider/Facility ID you wish to register. Your PIN will be mailed to the physical location of the practice/facility, sent via U.S. mail, or if requested, it can also be emailed to you. The letter will be addressed to the physician/provider or the company officer (in the case of a facility) who signed the Confidentiality and Security Guidelines form.

What do I do once I receive the PIN?

Every practice/facility/institution must designate a System Administrator (SA) upon receipt of the PIN. The SA should be someone familiar with information technology and security practices. The contracted physician/provider (or company officer for the

facility/institution) may choose to act as the SA, or delegate that responsibility to a staff member who can meet the criteria outlined in the Confidentiality and Security Guidelines form.

The SA will have authorization to create and manage staff accounts for all staff members whose job duties require access to BCBSRI.com. The SA will perform an annual audit to verify that appropriate security safeguards are being followed.

What are staff accounts?

Staff accounts are controlled-access accounts created by the SA for use by office staff. The SA can enable or disable certain features for a particular user and view staff account activity.

Can a system administrator (SA) create staff accounts for more than one (multiple) staff member(s)?

Yes, in accordance with state and federal privacy rules, the SA can create staff accounts on a need-to-know basis. In other words, staff accounts should be created and assigned only to staff members who have a need to access BCBSRI information to perform their job functions as related to payment or healthcare business functions. For instructions on how to create a staff account, go to "Account Access" and select "Manage Staff Accounts."

Is the system administrator (SA) expected to handle password reset operations?

Not necessarily. All active users can reset their own passwords online using the "Forgot Password?" feature on the sign-in page. The SA can also reset a password for a staff account. For instructions on how to reset a password, please call the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050.

If a staff member leaves the practice or facility/institution, how soon should his or her access to BCBSRI.com be revoked?

Access to BCBSRI.com should be immediately revoked for individuals who are no longer employees of the practice or institution. This is in accordance with confidentiality laws and industry-standard security procedures. The practice or institution should anticipate an employee's last day of employment to ensure that access is terminated as soon as he or she leaves the organization.

If a staff member changes roles within the practice or institution, should his or her access to BCBSRI.com be revoked?

In accordance with confidentiality laws and industry-standard security procedures, staff access should be re-evaluated whenever there is a change in an employee's job or role. If

a person had access to BCBSRI data, but is later transferred to another area, access to BCBSRI data should be reconsidered by the SA.

What must the system administrator (SA) do if inappropriate or unauthorized access is discovered?

The SA must notify the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050 within one (1) business day after becoming aware of any inappropriate or unauthorized access. “Inappropriate” or “unauthorized” access means that a staff member accessed BCBSRI member information without having a “need to know.”

Can a SA create a staff account for the practice’s billing service company to use?

Yes, provided that the billing service company is a business associate of the practice or institution, and that a HIPAA-compliant business associate agreement is in place. The SA is then authorized to create a staff account for the billing service company. Since billing companies should only be accessing Protected Health Information (PHI) on a need-to-know basis, it is important that staff accounts be created for their use of specific Web information. The SA is responsible for monitoring appropriate access for all business associates, as well as access by authorized members of his or her staff.

Electronic Claims Submission

Studies have shown that providers can see a substantial savings by submitting claims electronically. Statistics also show that claims submitted to BCBSRI electronically and in a HIPAA-compliant format adjudicate faster because they meet our clean claim specifications more often. BCBSRI is dedicated to servicing our providers in their efforts to submit electronically and in a HIPAA-compliant format. If your practice is interested in converting your systems, and wishes to move from paper to electronic claims submission, please visit BCBSRI.com, and go to Providers>HIPAA Transactions>HIPAA Transaction Documents. To contact BCBSRI’s EDI & Electronic Information Exchange team for more information please send an e-mail to hipaa.edi.support@bcbsri.org.

HIPAA Security Information

The Privacy Regulation of HIPAA became effective on April 14, 2003 and required us to implement specific safeguards to protect the privacy of health information. The next phase, the HIPAA Security Regulation, became effective on April 20, 2005. The Security Regulation requires health plans (including employer group health plans), healthcare clearinghouses, and healthcare providers to develop safeguards specifically to protect electronic health information.

What is the HIPAA Security Regulation?

The HIPAA Security Regulation defines specific standards and controls that must be in place to protect the confidentiality, integrity, and availability of electronic protected health information (ePHI). ePHI is information transmitted over the Internet and/or stored on a computer, CD, disk, magnetic tape, or other related means. This includes ePHI that is created, received, maintained, or transmitted. You can find the final Security Rule in the *Federal Register* of February 20, 2003.

Do I have to comply with HIPAA?

Any covered entity—a health plan (including an employer group health plan), a healthcare clearinghouse, and/or a healthcare provider—that files claims or other transactions electronically must comply with all the requirements of the HIPAA Transactions, Privacy, and Security Regulations.

How can I learn more about HIPAA Security?

The U.S. Department of Health & Human Services (HHS) Office of Civil Rights (OCR) publishes a website devoted to HIPAA privacy and security at:
www.hhs.gov/ocr/privacy/hipaa/understanding/index.html (last viewed November 2013).

Links for an unofficial combined HIPAA regulation, and official versions of the HIPAA statute can be found at: www.hhs.gov/ocr/privacy/hipaa/administrative/combined (last viewed November 2013).

Are small provider practices exempt from HIPAA Transactions and Code Sets regulations?

No. Regardless of practice size, all providers transmitting designated transactions electronically are subject to the HIPAA Administrative Simplification requirements. For more information on HIPAA Transactions and Code Sets regulation, please visit the Centers for Medicare & Medicaid Services (CMS) website at:
www.hhs.gov/ocr/privacy/hipaa/administrative (last viewed November 2013).

Will BCBSRI provide financial assistance to providers for compliance with HIPAA regulations, billing entities, or accounts receivable entities?

Compliance with the regulations is a federal requirement directed to all health plans, healthcare clearinghouses, and healthcare providers. As such, BCBSRI has not adopted a financial assistance program.

What is the process for obtaining the “production green light” for submitting ANSI X12 transactions?

In general, the main steps of the process for obtaining the “production green light” are:

- Complete the Trading Partner Agreement (TPA).
- Complete the Connectivity Form – EDI Data Transfer Worksheet
- Register for Foresight testing for each desired transaction. (Phase 1)
- Successfully test files (edit levels 1 through 7) using the Foresight Online Validator Tool.
- Successfully test files through the BCBSRI Partner end-to-end testing environment. (Phase 2)
- Submit/receive ANSI X12 transactions in a day-to-day production environment.

BCBSRI developed a partner testing approach to ensure trading partner transactions are HIPAA-compliant and meet BCBSRI’s business rules. The extensive testing required during the Partner Testing phase should result in a smooth transition to production. For more information on HIPAA Partner Testing and qualifying for production, contact BCBSRI’s EDI & Electronic Information Exchange team by e-mail at hipaa.edi.support@bcsri.org.

Why does BCBSRI require me to sign a Trading Partner Agreement (TPA) when other payers don’t have this requirement?

BCBSRI requires you to sign a TPA to protect the security of our members’ health information. Since the transmission of EDI transactions allows external parties to access components of our production network, it is imperative for security purposes that we only allow "trusted partners" to have submission privileges. Using the TPA ensures that both parties understand and agree to the "rules of engagement" before any production transmission takes place. CMS has recommended their usage to be a “good business practice,” and most Blue Cross and Blue Shield plans require a signed and executed TPA prior to the trading partner conducting “production” EDI with BCBSRI. Since our requirement was first implemented, we’ve worked with external trading partners to develop a TPA that is generally agreeable to both the transmitters of data and to the BCBSRI operational staff.

Where can I get a copy of BCBSRI’s Companion Guide for submitting/receiving Corporate ANSI X12 transactions?

All of BCBSRI’s Companion Guides are available to be downloaded on BCBSRI.com. Go to Providers>HIPAA Transactions>HIPAA Transaction Documents.

How are workers’ compensation claims handled?

Since workers’ compensation programs are not covered by any of the various components of the HIPAA legislation, workers’ compensation is outside the scope of

HIPAA regulations. Therefore, BCBSRI allows submission of the 837 with non-standard codes for workers' compensation. If non-standard health service codes are used, the qualifier should be either 'ER' or 'WK', (SV101 for 837P or SV202 for 837I at the 2400 level), and the claim must be marked as work-related (in the CLM-11 field) to avoid edit rejects. BCBSRI is free to accept any of the HIPAA transactions with non-covered entities. In those cases, non-standard code sets are allowable as long as both sides of the relationship are in agreement.

The following information from the federal register explains how workers' compensation programs are not considered a "covered entity" under the federal HIPAA statute: "We recognize that non-HIPAA entities such as workers' compensation programs and property casualty insurance accept electronic transactions from health care providers, however, Congress did not include these programs in the definition of a health plan under section 1171 of the Act."

"The statutory definition of a health plan does not specifically include workers' compensation programs, property and casualty programs, or disability insurance programs, and, consequently, we are not requiring them to comply with the standards. However, to the extent that these programs perform health care claims processing activities using an electronic standard, it would benefit these programs and their healthcare providers to use the standard we adopt."

How is an 837 claim that has more than 28 lines handled within BCBSRI?

We accept the HIPAA limits, 50 lines for Professional claims and 999 lines for Institutional claims. We can process 50 service lines per professional claim, and 98 service lines per institutional claim. Any claims that we receive with more than 50 or 98 lines (depending on the type) will be split prior to adjudication. The claim is split into multiple claims with the Repository ID, Split Claim Indicator, Patient Control Number, and Line Indicator being entered on the claims.

The Line Indicator will show the original number of the line it had. From that point, the split transactions are independent claims in our system. Parts of the original claim could be paid in different settlements. However, the provider's original control information (including the provider-submitted original line number) will be returned in the 835 (Electronic Remittance advice).

Should there always be a 999 Acknowledgement for each 837 file submitted?

You should always expect a 999 Acknowledgement and Plain Language 999 for each 837 file you submit. If a reasonable time has elapsed since file submission and you have yet to receive the 999, please contact the IT Service Desk at (401) 751-1673 or 1-800-343-5743.

It appears that the BCBSRI translator is rejecting a batch as soon as it encounters an error. Is this true? How do I know what kind of data errors trigger a failed 999?

The BCBSRI translator will attempt to edit as much as possible. 837 edits are for level 1; therefore, any deviation from the Technical Report Type 3 (TR3) would be flagged as an error. The IK5 segment indicates whether the batch was accepted or rejected. There can be multiple IK3 and IK4 segments to point to the error or problem. It is a matter of reviewing the submitted data based on the 999 information.

Once an 837 claim file is submitted to BCBSRI, when will the claims be processed and adjudicated?

Claims processing and adjudication are done nightly Monday through Friday. Any file submitted before 5:00 p.m. will be included in that night's work. Files submitted during the weekend will be included in Monday night's work unless there is a special weekend run. The 5:00 p.m. cutoff applies to production claims only.

Will providers continue to receive the current paper settlement summary?

Yes. The current paper summary will be produced as a "business report" and made available to the submitter via the Correspondence Center on BCBSRI.com. The format of the report has changed slightly to accommodate new fields such as National Provider Identification (NPI).

Will BCBSRI offer “turnkey” conversion to the 835 ERA RA? In other words, will all RAs be in 835 format as of a predetermined date?

No. BCBSRI will not provide conversion to 835 settlements in "turnkey" fashion. We will create 835 RAs only upon a written request from the trading partner or provider. This request must be submitted to the EDI & Electronic Information Exchange Department to determine that the EDI setup is complete. Then, the provider database staff will update their database(s) to indicate that the provider is setup to receive 835 transactions in production. Once the database is updated, all future settlements will be presented to the provider in ANSI X12 835 format, regardless of the date of service for the claims on that settlement.

After getting the “go ahead” for submitting ANSI X12 claims in production, will I need to make changes? If so, what are those changes?

Yes. You will need to make a few changes. The first change will be to the first position of the Submitter ID (ISA06, GS02 & 1000A NM109), which will change from a “T” (Test) to a “P” (Production). The second change will be to the ISA15, changing from a ‘T’ for Testing to a ‘P’ for Production submission. The last change will be the use of a new PRODUCTION mailbox ID and password that will be randomly generated to provide a secured environment. An EDI & Electronic Information Exchange staff member will provide you with your new password and the process for moving into a production

environment. It is also important that a trading partner monitor their mailbox to review their Provider Control Reports.

I am in end-to-end partner testing, and I did not receive a 999 Acknowledgement within a short time after submission. Why?

The most likely cause of this is an error in the data file, which resulted in an error in our translator software. Without the correct data, our software cannot determine where to send the 999 Acknowledgement information. If you do not receive a 999 Acknowledgement within a few minutes after transmitting the test file, please contact the EDI & Electronic Information Exchange team by email at hipaa.edi.support@bcbsri.org.

I have “Provider Control Reports” in my mailbox directory. What is the purpose of these reports?

The Provider Control Reports identify claims that were not accepted for claims adjudication. This reject report will list any claim that is rejected from our front-end edit process and the reason the claim rejected. These claims have not been accepted for processing and must be corrected and retransmitted to receive payment. Providers must download these reports for the information; the mailbox is purged after 30 days. **The Provider Control Report Error Message Codes Guide** provides trading partners/providers with information regarding the reject error codes generated by BCBSRI when electronic claims are rejected. This guide may be found at BCBSRI.com.

Please contact the Information Technology (IT) Service Desk at (401) 751-1673 or 1-800-343-5743 for all production issues and/or questions such as electronic claims transmission problems, difficulty retrieving Provider Control Reports, questions regarding the reject error codes, and 835 electronic remittance advice issues.

CHAPTER 10

FOR BEHAVIORAL HEALTH PROVIDERS

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Behavioral Health Overview and Contact Information

As part of our ongoing commitment to streamlining processes, improving efficiencies, and strengthening communications, BCBSRI offers our providers a variety of resources to quickly find up-to-date information. To avoid disruption of your business activities, BCBSRI will direct all inquiries to the most appropriate resource as quickly and efficiently as possible.

BCBSRI.com

BCBSRI.com is your one-stop destination for a wide range of information regarding our healthcare products, member eligibility, current policies and procedures, practice guidelines, and utilization review criteria. The majority of this information is only accessible to registered providers and their staff.

Please note: BH providers should be checking BCBSRI.com regularly under the “Alerts” section to review any policy changes, fee schedule updates, provider training opportunities, or general notifications.

Physician and Provider Service Center

(401) 274-4848 or 1-800-230-9050

Hours: Monday through Friday, 8:00 a.m. to 8:00 p.m.

You or your staff members can call the Physician and Provider Service Center with specific inquiries, including:

- Routine member eligibility and benefit information
- Credentialing
- Complaints and grievances
- Claims status or issues
- Web access issues
- Policies and procedures

Provider Relations Representative

As a participating provider, you have a Provider Relations Representative who is assigned to your office based on your geographic location. Your representative is responsible for ensuring that you have all the information you need to function successfully as a participating BH provider. He or she can also personally facilitate problem resolution on your behalf.

Any questions can be directed to your representative, including inquiries regarding:

- Policies and procedures
- BCBSRI.com navigation
- Office operations

Please call (401) 274-4848 to contact your provider relations representative.

Behavioral Health Department

You can contact members of our BH Department directly:

Rena Sheehan, LICSW, MBA, Director of BH

Phone: (401) 459-1467

Email: rena.sheehan@bcbsri.org

Dr. Tracey Cohen, BH Medical Director

Phone: (401) 459-5741

Email: tracey.cohen@bcbsri.org

BCBSRI's BH Partner: ValueOptions

1-800-274-2958

Hours: 24 hours a day, seven days a week

BCBSRI has partnered with ValueOptions, which is the primary contact for members seeking BH treatment for mental health and/or substance use disorders. ValueOptions is a resource for members and providers who have questions or concerns related to BH care and services. They can assist members with:

- Preauthorization to higher levels of care, including inpatient mental health and substance abuse programs, residential programs, Partial Hospitalization Programs, and Intensive Outpatient Programs
- Referrals to all levels of care and outpatient providers such as psychiatrists, clinical nurse specialists, BH specialists, or other community-based support
- Care coordination and case management
- Complaints and appeals

The ValueOptions clinical team is colocated in the BCBSRI offices at 500 Exchange St. in Providence.

ValueOptions Intensive Case Management Program

With the help of ValueOptions, BCSBRI members are supported in maintaining and improving their health. The ValueOptions Intensive Case Management Program provides educational information, support for treatment adherence, coordination of care, and preventive care reminders.

Having a ValueOptions Intensive Case Manager may benefit members who:

- Are not adherent with their medical regimen.
- Need assistance with aftercare appointments.
- Have social/environmental situations and/or other barriers to health.
- Have transportation issues.
- Have comorbid conditions.

This telephonic program is available 8:30 a.m. to 5:00 p.m., Monday through Friday.

How to Refer Patients to Case Management

Your collaboration is essential to reaching the people who need this program the most, so please refer eligible members for additional assistance. To make a referral, please contact ValueOptions at 1-800-274-2958, press 3, and then press 2 to reach a care manager.

ValueOptions Contact

Susan Lake, Clinical Director
Phone: (855) 833-1959, extension 228601
Email: susan.lake@valueoptions.com.

Questions about the ValueOptions program may also be directed to Rena Sheehan, LICSW, MBA, Director of BH, at (401) 459-1467.

Appeals

Appeals may be requested verbally or in writing. Written requests should be sent to:

ValueOptions
Attention: Clinical Appeals
PO Box 129
Latham, NY 12110

Written requests can also be faxed to ValueOptions at 1-855-378-8309. If you have questions about an appeal, please call ValueOptions at 1-800-274-2958, Monday through Friday, 8:00 a.m. to 4:30 p.m. ET.

Complaints

For information on filing a complaint, please refer to Chapter 3, page 40.

Quality of Care Issues

BCBSRI investigates quality of care complaints. Occurrences of actual or potential poor medical and behavioral health quality are identified through our staff, members, regulators, providers, and delegated organizations. Quality of care complaints are handled by the Quality Management Department. Types of quality issues include:

- Misdiagnosis, incomplete assessment or evaluation, or performing the wrong treatment or procedure
- Site or medical review that indicates inappropriate treatment, lack of informed consent, or failure to provide necessary services (including preventive health), or inadequacy of facilities or clinic/individual practices
- Concerns about possible provider impairment

If you are contacted about a quality of care complaint, please respond as requested and collaborate towards resolution.

If you have a quality of care issue to report, please email QOC@bcbsri.org. Please send the email encrypted by typing [encr] as the first word in the subject line.

You can also contact BCBSRI's Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050 to report a quality of care complaint.

Applied Behavioral Analysis

BCBSRI provides coverage for applied behavioral analysis (ABA) services for all large employer groups as part of the Autism Mandate, RI General Law 27-2011-1. Self-funded accounts have the option to elect or decline coverage of ABA services.

ABA services are generally rendered through home-based treatment services. ABA is defined per RI General Law 27-2011.11-2 as follows:

- “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvements in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- “Autism spectrum disorders” means any of the pervasive developmental disorders as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

BCBSRI supports the best practices and principles guided by the Behavioral Analyst Certification Board (BACB). The administration and oversight of ABA plans is more intensive than plans administered through home-based treatment services as ABA incorporates discrete trial teaching. Best practices for ABA include a comprehensive team that is led by a Board Certified Behavioral Analyst (BCBA) or a doctoral-level licensed healthcare provider with experience in behavioral analysis.

Benefit Coverage

The benefit coverage for ABA includes pharmaceuticals, physical therapy, speech therapy, counseling, psychiatry, and occupational therapy services for the treatment of autism spectrum disorders, as defined in the most recent edition of the *DSM*. Please note:

- Physical therapy, speech therapy, occupational therapy, counseling, psychiatry, and pharmaceutical services are covered to the extent such services are a covered benefit for other diseases and conditions under such policy.
- Benefits and limits may apply and it is good practice to check the member's coverage by calling the BCBSRI behavioral health line at 1-800-274-2958. Benefits under the state mandate continue until the covered individual reaches age 15.

Preauthorization

All ABA providers are required to contact ValueOptions to obtain prior authorization of ABA services. Please call ValueOptions at 1-800-274-2958 for preauthorization of ABA.

The process for ABA preauthorization is as follows:

1. Request for authorization of ABA therapy should be made via phone or fax.
2. ValueOptions' clinician reviews the request, including diagnosis, treatment plan, and clinical summary.
3. ValueOptions makes an outbound call to the provider to obtain any missing information, if necessary.
4. Authorization is entered, and a letter is generated for the approved ABA services and codes.

Helpful Resources

These resources on ABA may be useful:

- BACB: www.BACB.com
- Autism Speaks: www.autismspeaks.org

BCBSRI's Commitment to Quality

As part of our commitment to quality, BCBSRI reviews Healthcare Effectiveness Data and Information Set (HEDIS) measures. These are standardized performance measures designed to ensure that consumers and purchasers of health plans have the information they need to reliably compare the performance of managed care plans. It is sponsored and maintained by the National Committee for Quality Assurance (NCQA), which modifies the HEDIS measures annually and makes them available to interested organizations. One of the measures of great importance to us is after care follow-up after an inpatient stay within seven days of discharge.

ValueOptions has established the Aftercare Follow-Up Program as an initiative to improve quality and coordination of care for members discharged from an inpatient behavioral health stay. This initiative ensures members follow up with their after care appointments within seven and 30 days of discharge. ValueOptions contacts the member within three business days to remind about and confirm an appointment and will contact the provider after seven days to verify attendance.

If a member(s) has an inpatient mental health admission, you can expect to receive a call from ValueOptions to confirm that a member has attended his/her aftercare appointment. It is our expectation that you collaborate in this effort with ValueOptions.

BCBSRI has an internal committee structure to continuously evaluate and monitor quality improvement initiatives that positively impact member and provider outcomes. From time to time, we may ask you to collaborate or help us implement identified initiatives.

Outcomes Tool for Outpatient BH Providers

BCBSRI expects all BH outpatient providers to implement the ValueOptions On Track Patient Assessment and Outcome Tool.

We consider the adoption of the On Track Program to be a move towards higher quality and more efficient care. It provides real-time, meaningful information that will assist you in meeting your patient's needs. Programs like On Track have been shown to improve patient outcomes, and our goal is to help you demonstrate successful outcomes of the care you provide. The use of these tools and participation in the program are voluntary for both you and the patient. Ultimately, you are responsible for determining whether or not On Track's assessment tools are appropriate for your patients.

BCBSRI recommends using the Client Feedback Form (CFF) at the initial intake and the third session, then every third session thereafter. The CFF may be used with non-ValueOptions

clients. Make sure to use the most recent version of the CFF, which has a field to identify whether it is for a BCBSRI member. All completed CFFs should be **faxed to 1-866-408-7240**.

For Additional Information

To learn more about On Track, please log in to the secure Provider section of BCBSRI.com to review:

- The On Track FAQ
- The On Track Quick Guide
- The On Track Manual

How to Access On Track

To access On Track, please go to the VO Provider Connect website at:
https://www.cci-acorn.org/register_bcbsri.asp.

This site allows you to:

- Print the CFF to give to your patients
- Review scores and feedback for previously submitted CFFs

If you are a first-time user, please log in use your personal BCBSRI ID and to the website below:
<https://www.valueoptions.com/pc/eProvider/providerRegisterFromLogin.do>

Rights & Responsibilities

As a BCBSRI BH provider, you understand how important it is to be aware of the various clinical and administrative aspects of network participation. Please refer to the pages 14–47 for important information about your network participation. Here is other information important to your practice:

Provider Responsibilities

Please review pages 14-21.

Provider Audits

Please be aware that your medical records may be audited at any time.

Fraud & Abuse

Please see information at www.bcbsri.com/about-us/healthcare-fraud.

Patient Access

Safe and easily accessible practice sites and efficient office management are essential for ensuring high-quality care and services. All BCBSRI BH providers must ensure that they provide

convenient, timely, and safe access to needed care. BCBSRI works with our participating physicians/providers to ensure that their physical premises and operating procedures meet our standards.

BCBSRI measures member access by specific standards based on indicators for convenience, timeliness, and safety. BCBSRI monitors compliance with access standards and incorporates it into our quality improvement activities. Regulatory agencies, such as the Rhode Island Department of Health and Rhode Island Department of Human Services, and accrediting organizations, such as the National Committee for Quality Assurance (NCQA), also place great emphasis on member access.

BCBSRI measures accessibility and premise capabilities by the standards described below. For additional information, please see pages 25-30.

Office Hours

Each practice site must be open a minimum of three days and 20 hours each week, unless fewer hours have been approved by BCBSRI.

After-Hours Coverage

All BH providers will provide for continuous coverage, 24 hours a day, seven days a week. Phone calls received by office staff should be returned the same day. After-hours calls will be responded to by the on-call clinician within one hour of the time they were placed by the patient.

The following coverage requirements apply to both medical and behavioral healthcare providers:

- All BH providers must have at least one person other than themselves for coverage in the event of illness or absence from the service area. Coverage arrangements must be in place in case face-to-face contact with the member is necessary.
- Coverage may be performed personally or through the use of an appropriately qualified professional(s) who is either contracted and credentialed by BCBSRI or meets all qualifications and agrees to be bound by the same administrative and contractual obligations.
- A non-physician may cover a physician, as long as the appropriate level of service can be provided and the non-physician has back-up physician supervision or collaboration for consultation, as needed.
- Coverage must reflect appropriate qualifications for the specialty.

Appointment Wait Times

Appointments must be available daily during regular office hours. Appointment times must be left open daily for emergencies and urgent care, unless the staff can add appointments without disrupting patient flow. In-office wait times should be **30 minutes or less**, with the exception of same-day urgent visits, which may have a longer wait time. Wait times for services must meet the standards below.

- **Emergency care** – Patients should receive care for a non-life-threatening emergency within **six** hours or be referred as medically necessary.
- **Urgent care** – Patients should receive urgent care within **48** hours.
- **Routine care appointments for behavioral health** – Appointments must be made within **10** business days for all BCBSRI products.
- **Post-hospitalization visit** – Members must be seen within **seven** days of discharge.
- **On-call coverage** – This coverage should be available at all times.

Return of Calls Requirements

The following guidelines must be followed by all practitioners for returning calls:

- **Calls triaged by office staff** – Same day
- **Off-hours calls** – Within one hour
- **Emergency room calls** – Within **30** minutes

Physical Accessibility

For information on physical accessibility and site safety requirements, please review pages 27-29. Please note: In the event you have a waiting area, it must have adequate space.

Compliance Measures

For information on compliance measures, please review page 30.

Medical Records

Please review pages 29-34 for information on medical records. Audits are conducted against these standards. Members' medical records must contain, at a minimum, the following and be kept for seven years:

Standard	Explanation
	Initial Note
1. All pages in the medical record contain patient identification.	• Patient's first and last name, or • Patient's first initial and last name, or • Patient's Social Security Number, or • Any physician office-generated number that remains unique to that patient

Standard	Explanation
2. The medical record contains documentation of each patient's personal and biographical data.	There is a form or designated place in the record that contains but is not limited to the following non-medical information: • Date of birth • Address • Employer (if applicable) • Home/work telephone number (if applicable) • Marital status OR The same information is maintained in the computer and is available each time the patient is seen.
3. Name, relationship, address, and telephone number of next of kin or responsible person is noted in the chart.	The record includes the person's name, address, phone number (work, if applicable, and home) and relationship to patient of the person to contact in case of emergency. • For children to the age of 18, the name, relationship, address, and telephone number of the responsible person is to be documented in the medical record.
4. Notes are signed or initialed by provider.	All entries in the medical record contain author identification as follows: • Author initials and/or name/signature handwritten, stamped, or electronic, or • A number assigned to that physician or practitioner may be used.
5. All entries in the medical record are dated. <i>For prescribers only</i>	Entries in the medical record are dated. The entries include any originating from personnel in the office/facility, including: - Progress notes - History - Prescription requests or refill information - Phone call forms Reports generated by separate agencies are not considered entries (e.g., psychological testing, laboratory reports, emergency encounter forms).
6. The provider's note states the presenting complaint and history.	The note includes the following documentation (at a minimum): • The presenting complaint • Behavioral health history including prior hospitalizations, medications, outcomes • Precipitating events • A diagnosis • Any risk factors relevant to the treatment • Documentation of a return visit • A treatment plan
7. Entries in the medical record are legible to someone other than the author.	• Entries in the medical record can be interpreted by another user.
8. There is a list of all current medications documented in the medical record.	There is specific documentation of all medications currently taken, including dosages OR documentation should state "no medication." List should include prescription and known OTC medications.
9. The presence of known drug allergies and/or reactions to drugs is	There is consistency in the location of documentation, such as: • The outside cover of the chart • The inside cover of the chart

Standard	Explanation
prominently displayed in a uniform location in all medical records. <i>For prescribers only</i>	• Drug allergies handwritten in the medical record in a uniform place • A form in the record that addresses allergies and is filed in a uniform location • Computer field dedicated to documentation of allergies
10. Authorization to release patient information is dated and signed by patient.	Patient has signed a release of information form or “refused to sign” documented in medical record, giving permission to release information to a specific provider.
11. Substance use/abuse evaluation is present.	If present, there is documentation of the substance use history, including but not limited to age of onset, frequency of use, amount of use. Documentation of use or nonuse of alcohol or other substances, which includes but is not limited to alcohol/prescription drugs/street drugs and other chemicals, or “none.”
12. Past medical history is documented.	Past medical history is documented and includes: • Significant medical illnesses • Operations and/or injuries Past medical history may be located on the progress notes, an initial exam form, hospital discharge summary, or on a separate form.
13. Psychosocial history is documented.	Psychosocial history includes but is not limited to: • Developmental history for children and adolescents • Living situation, employment, relationships, social stressors • Cultural, language, spiritual issues • Strengths useful for treatment
14. Mental status evaluation is documented (within first visit).	There is documentation of current mental status that includes but is not limited to: • Appearance, thought process, thought content, perception, speech, motor activity, mood, affect, orientation, attention/concentration, judgment, insight, memory
15. There is documentation of risk assessment.	There is risk assessment documented that includes but is not limited to: • Severity and imminence of potential harm to self or others • History of suicidal gestures or attempts Information should be updated as clinically appropriate.
16. There is a complete list of DSM IV multi-axial diagnoses, supported by the clinical assessment.	There is specific documentation of five DSM IV diagnoses: • Principal and/or provisional diagnoses (Axis I and II) • General medical conditions (Axis III) • Psychosocial and environmental problems (Axis IV) • Global assessment of functioning (Axis V)

Standard	Explanation
17. A treatment plan addresses the DSM IV diagnoses and care plan.	There is specific documentation of: • Therapeutic intervention recommended • Short- and long-term goals/expected outcome
18. The medical record shows that appropriate adjunctive treatment referrals were made and resources utilized.	The medical record shows documentation of appropriate adjunctive treatment referrals and use of available community resources, including: • Information given to patient regarding specific referral to support groups (e.g., NAMI, AA, Alanon) • Discussion with patient regarding benefits of various groups, reason for referral, as related to diagnosis/problem list
19. There is documentation that the patient was informed of treatment plan.	There is documentation that patient has been informed of treatment plan. This is indicated either on a separate form in the medical record or referred to in provider's notes.
20. There is documentation of current medical providers.	There is documentation in the medical record that medical providers are to be involved and formally communicated with: • If none, so noted • If member refuses, so stated • Release of information signed and dated by member in medical record
Subsequent Progress Notes	
1. Subsequent progress notes reflect treatment and progress.	Visit notes reflect progress towards goals: • Review of current state • Update to treatment plan and revisions as appropriate to identify barriers to care • Evidence of member improvement or lack of • Documentation of referrals to other providers or services to address gaps in care • Evidence of member's involvement in treatment
2. There is documentation that the interventions are consistent with generally accepted Best Practice Standards for the member's diagnosis.	• Reference to Best Practice standards is encouraged. • Use of Standard Evaluation and Assessment tools is encouraged. • These can be part of a well-articulated treatment planning process.
3. There is documentation for visits that require use of the Interactive Psychotherapy Complexity Code 90785 that appropriately support the complexity.	The progress notes includes the following documentation: • Reflects the CPT code definitions of 90785
4. There is documentation for visits that require use of the 60-Minute Individual Psychotherapy Code 90837 and E/M Codes supports their use.	The progress notes should include the following documentation: • Reflects the CPT code definitions of 90837 and support at least a 53-minute visit. • E/M codes are documented per the CPT code definitions for the appropriate time, evaluation and management requirements.

Practice Changes to Report

Practice Site Changes

BCBSRI has established standards for geographic access by members to BH providers, and a change in address may impact member accessibility. All practice site changes should be reported by completing the appropriate forms and sending them to BCBSRI so that the necessary updates can be made. For your convenience, a Practitioner Change Form and Substitute W-9 Form are included in the Appendix and are also available in the Provider section of BCBSRI.com. BCBSRI works with our participating physicians/providers to help ensure their physical premises and operating procedures meet all established standards.

Change of Phone Number(s) or Reduced Practice Hours

Changing your phone number or reducing your practice hours has a direct impact on member access as well as BCBSRI's ability to communicate with the physician/provider. To inform BCBSRI of these changes, providers should complete either the Practitioner Change Form or contact the Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050.

BCBSRI will publish the new number(s) and/or hours in the BCBSRI provider directory, which is located on **BCBSRI.com** by accessing the "Find A Doctor" tool. Members who call BCBSRI will be given the new information as soon as the changes take effect.

Voluntary Network Participation Terminations

All providers voluntarily terminating their network participation are required to notify BCBSRI. A 60-day advance notice is a contractual obligation. This is particularly important as members must transfer to another provider when appropriate.

- For your convenience, a Voluntary Termination Form is located in the Appendix and is also available in the secure Provider section of **BCBSRI.com**.
- If you are a Medicare BH provider, please review pages 25-29 for additional information.

It is not considered a termination if you are leaving a location, but will remain participating at another location. In those cases, you should complete a Practitioner Change Form.

Email Information

It is essential that BCBSRI has your current email address to facilitate communication and to send important information for your practice more efficiently. Please provide your current email address on the Email Address Update Form and mail or fax it to BCBSRI. This form is included in the Appendix and is also available in the Provider section of BCBSRI.com.

Appendix

Physician/Provider Forms and Additional Information

TABLE OF CONTENTS

- Email Address Update Form
- Physician/Provider Claim Adjustment Request Form
- Practitioner Change Form
- Provider Appeal Request Form
- Referral Form
- Substitute W-9 Form – Request for Taxpayer Identification Number and Certification
- Voluntary Termination Form



Email Address Update Form

At BCBSRI, we primarily communicate with physicians/providers online and through email. To ensure that you receive important updates, please provide your current email address in the form below. It will be kept confidential and only used for information related to being a BCBSRI network physician/provider.

Date: _____

Provider name: _____

Office contact: _____

Phone number: _____

Office contact email address: _____

Please list any old email addresses that may need to be deleted from our system (if any):

Practice Information

Provider NPI: _____

Group NPI: _____

Group name: _____

Email address: _____

Address: _____

City: _____ State _____ ZIP _____

Please return this completed form by **fax to (401) 459-1774**. Or you can mail it to:

Blue Cross & Blue Shield of Rhode Island
Attn: Provider Information, Management & Operations
500 Exchange Street
Providence, RI 02903

Physician/Provider Claim Adjustment Request Form

Type of Claim (check one):

- | | |
|--|---|
| ☐ BCBSRI
☐ BlueCard
☐ New England Health Plan (NEHP)
(CTN, CTP, MTN, MTP, NHN, NHP, MEN, MEP) | ☐ FEP
☐ Workers Compensation |
|--|---|

Date: _____

Provider Name: _____ Group Name: _____

National Provider Identifier (NPI): _____

Office Contact Person: _____ Phone: (____) _____

Member Name: _____ Member ID: _____

Attachment:

- | | |
|--|--|
| ☐ CMS-1500 Claim
☐ UB – 04 Claim Form
☐ Other (please specify): _____ | ☐ BCBSRI/BlueCHIP Plans Settlement*
☐ Another Carrier Settlement* |
|--|--|

*Note: Please do not shade or highlight line items when submitting settlements. Our imaging system is unable to identify shaded/highlighted areas. Please use asterisks to identify specific line items within your settlement. To comply with HIPAA, all other non-pertinent information on the settlement should be blacked out.

Reason for Adjustment:

- | | | |
|---|--|--|
| ☐ Not our patient
☐ Duplicate payment
☐ Service not performed
☐ Incorrect DOS billed
☐ Incorrect reimbursement | ☐ Incorrect denial for primary primary payment (submit EOB)
☐ Incorrect # of units paid
☐ Incorrect provider # billed
☐ Incorrect CPT® code | ☐ Incorrect ICD-9 code
☐ Referral/pre-auth obtained
☐ Incorrect member # billed
☐ Corrected claim copy (original submission error)
☐ Incorrect NPI # billed |
|---|--|--|

☐ Other (please specify): _____

Additional Comments: _____

Please be sure to submit all supporting documentation to:

ADJUSTMENTS CANNOT BE MADE WITHOUT SUPPORTING DOCUMENTATION

**Attn: Basic Claims Administration – Inquiry Unit – 00066
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903-2699**

DIRECTIONS: Please check all that apply and fill in sections as directed.

☐ **Tax ID Change** – Complete Sections 1 and 2. **Attach a completed W-9 form.**

☐ **Change in Practice Information**

- **Mailing and/or payment address for existing office** – Complete Sections 1 and 2.
- **Closing existing site, opening new site or joining existing practice** – Complete Sections 1, 2, 3A, and 3B.
- **Change in office hours, covering physicians and accepting/not accepting new patients** – Complete Sections 1, 3A, and 3B.

NOTE: If you are adding a new practice location in another state, please provide us with a copy of your license and federal DEA to practice in that state.

When completed, please fax the required documentation to (401) 459-1774 or (401) 459-2099, or mail it to:

Provider Information Management and Operations

Blue Cross & Blue Shield of Rhode Island
500 Exchange Street, Providence, RI 02903

If you have any questions regarding this form, please call The Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050.

Section 1 – General Information

Practitioner name: _____ Date: _____

Degree: _____ Date of birth: _____

Name and title of person completing form: _____

E-mail address: _____ Phone number: _____

National Provider Identifier(s)

NPI Type 1: _____ Tax ID number: _____

NPI Type 2: _____ Tax ID number: _____

Primary specialty: _____

Secondary specialty: _____

Do you speak a foreign language fluently? ☐ Yes ☐ No

Please list all languages spoken: _____

Description of requested change: _____

Section 2 – Mailing and/or Payment Address Change

New Mailing Address

Effective date of change: _____

Street: _____

City: _____ State: _____ ZIP: _____

Old Mailing Address

Street: _____ Phone: _____ Fax: _____

City: _____ State: _____ ZIP: _____

New Payment Address

Effective date of change: _____

Street: _____

City: _____ State: _____ ZIP: _____

Old Payment Address

Street: _____ Phone: _____ Fax: _____

City: _____ State: _____ ZIP: _____

Section 3A – Change in Practice Information**IMPORTANT: Please attach W-9 form****A CLOSING / ADDING ADDITIONAL SITES**

If this information requires a change in your practice(s) hours, covering physicians, and whether you are accepting/not accepting new patients, please also complete Section 3B on the next page.

Old Office

Name of Group/Clinic: _____
Name of Group/Clinic Manager: _____
Street: _____
City: _____ State: _____ ZIP: _____
Phone: (_____) _____
Business E-mail: _____
Date practice closed (if applicable): _____

New Office #1 (Primary Office)

Effective date of change: _____
Name of Group/Clinic: _____
Name of Group/Clinic Manager: _____
Street: _____
City: _____ State: _____ ZIP: _____
Phone: (_____) _____
Fax: (_____) _____
Business E-mail: _____

Payment Address

Street: _____
City: _____ State: _____ ZIP: _____
Phone: (_____) _____
Fax: (_____) _____
Tax ID Number: _____ – _____
Type 2 NPI: _____

Mailing Address

Street: _____
City: _____ State: _____ ZIP: _____

Is this office handicapped accessible? ☐ Yes ☐ No
Is it equipped with TDD equipment for the hearing impaired? ☐ Yes ☐ No
Do any of your staff members speak a foreign language fluently? ☐ Yes ☐ No
Please list all languages spoken: _____

COMMENTS _____

New Office #2

Effective date of change: _____
Name of Group/Clinic: _____
Name of Group/Clinic Manager: _____
Street: _____
City: _____ State: _____ ZIP: _____
Phone: (_____) _____
Fax: (_____) _____
Business E-mail: _____

Payment Address☐ **Same as Primary Office Information**

Street: _____
City: _____ State: _____ ZIP: _____
Phone: (_____) _____
Fax: (_____) _____
Tax ID Number: _____ – _____
Type 2 NPI: _____

Mailing Address☐ **Same as Primary Office Information**

Street: _____
City: _____ State: _____ ZIP: _____

Is this office handicapped accessible? ☐ Yes ☐ No
Is it equipped with TDD equipment for the hearing impaired? ☐ Yes ☐ No
Do any of your staff members speak a foreign language fluently? ☐ Yes ☐ No
Please list all languages spoken: _____

New Office #3

Effective date of change: _____
Name of Group/Clinic: _____
Name of Group/Clinic Manager: _____
Street: _____
City: _____ State: _____ ZIP: _____
Phone: (_____) _____
Fax: (_____) _____
Business E-mail: _____

Payment Address☐ **Same as Primary Office Information**

Street: _____
City: _____ State: _____ ZIP: _____
Phone: (_____) _____
Fax: (_____) _____
Tax ID Number: _____ – _____
Type 2 NPI: _____

Mailing Address☐ **Same as Primary Office Information**

Street: _____
City: _____ State: _____ ZIP: _____

Is this office handicapped accessible? ☐ Yes ☐ No
Is it equipped with TDD equipment for the hearing impaired? ☐ Yes ☐ No
Do any of your staff members speak a foreign language fluently? ☐ Yes ☐ No
Please list all languages spoken: _____

Section 3B – Change in Practice Information

B

GENERAL INFORMATION

☐ Practice Information

What is the average waiting time to obtain an appointment? (Please respond with a specific waiting time. "PRN" is not acceptable.)

Initial visits will be provided within _____ weeks.

Symptomatic/non-urgent visits will be provided within _____ weeks.

Urgent visits will be provided within _____ hours.

Are you accepting new patients? ☐ Yes ☐ No

Which age groups do you treat? ☐ All ages ☐ 0-13 years ☐ 14-18 years ☐ 19-65 years ☐ 65+ years

☐ New Office Hours Please indicate office hours at each location. (e.g., 9:00 a.m. — 5:00 p.m.)

Location	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Office #1							
Office #2							
Office #3							

☐ Changes in Covering Physicians/Associates

Please list current partners/associates in your practice and physicians/providers who cover for you, with their respective specialties.

If more than four practitioners, please use additional sheets.

Collaborative agreements and requirements are required for nurse practitioners, physician's assistants, nurse midwives, and clinical nurse specialists with prescriptive privileges.

NAME	DEGREE	SPECIALTY	PARTNER	COVERING	BOTH
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Are you available, or do you have available coverage, 24 hours per day, seven days per week? ☐ Yes ☐ No

How do you provide this coverage? (Please check)

- ☐ Answering Service
 ☐ Answering machine (with pager or cell phone number)
 ☐ Call Forwarding
 ☐ Cell Phone
 ☐ Home Phone



500 Exchange Street • Providence, RI 02903-2699

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

PROVIDER APPEAL REQUEST FORM

Date: _____

Office Contact Person: _____ Phone: (____) _____

Provider Name: _____ Group Name: _____

National Provider Identifier (NPI): _____

Member Name: _____ Member ID #: _____

Date of Service(s): _____

Type of Claim (check one):

- | | |
|---|--|
| ☐ BCBSRI | ☐ FEP |
| ☐ BlueCard | ☐ Workers' Compensation |
| ☐ New England Health Plan (NEHP) | |

Attachment:

- | | |
|--|---|
| ☐ CMS-1500 Claim Form | ☐ Supporting Documentation for an Appeal |
| ☐ UB-04 Claim Form | ☐ BCBSRI/BlueCHiP Plans Settlement * |
| ☐ Other (please specify): _____ | ☐ Another Carrier Settlement* |

*** Note:** To comply with HIPAA, all non-pertinent information on the settlement should be blacked out.

Reason for Appeal:

- | | | |
|--|--|--|
| ☐ Timely Filing | ☐ Office Visit denied as
included in surgical
procedure | ☐ Provider not
authorized for the
service |
| ☐ No Pre-Auth Obtained | ☐ Questioning global
reimbursement | |
| ☐ Other (please specify): _____ | | |

Additional Comments: _____

Submit Appeals to:
Attn: Grievance & Appeals Unit
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903-2699

Referral Form

Date: ____ / ____ / ____

Patient's Name: _____

Patient's ID #: _____ Patient's DOB: ____ / ____ / ____

Patient's Insurance Type: ☐ BlueCHIP plans
☐ All other Blue Cross & Blue Shield of Rhode Island (BCBSRI) plans

Referring Provider's Name: _____

Address: _____

Telephone #: _____ Fax #: _____

☐ Referring provider's NPI number: _____
(Specialists – Please use box 17b when filing a claim.)

Referred to: _____

Address: _____

Telephone #: _____ Fax #: _____

Referral Valid From: ____ / ____ / ____ to ____ / ____ / ____
(Note: Number of visits cannot be specified.)

Patient is being referred for:

- ☐ Consultation only
- ☐ Consultation and treatment
- ☐ Treatment only

If you are referring a New England Health Plan (NEHP) patient out of state, please fax this completed form to BCBSRI Health Services Management at (401) 272-8885. NEHP referrals require the appropriate ICD-9-CM diagnosis code.

Please List Code(s) _____

Reason for Referral: _____

Diagnostic Tests/Procedures Requested: _____

Note: Communication is required between PCP and specialist.

PCP's preferred mode of communication is: ☐ Telephone ☐ Fax ☐ Mail

Substitute Form W-9

Request for Taxpayer Identification Number and Certification

Federal regulations require us to obtain and report accurate Taxpayer Identification Numbers (TIN) on payees of certain types of payment we make. This information is reported each year to the Internal Revenue Service on Form 1099. If you do not provide us with this information, your payments may be subject to 28% federal income tax backup withholding. Failure to furnish your correct TIN to us may also be subject to a \$50 penalty imposed by the Internal Revenue Service under Section 6723.

Please provide the information requested on the bottom of this form and return it to us within 30 days in the enclosed envelope. Enter your TIN in the appropriate box. The TIN provided must match the name given on Part I to avoid backup withholding. If you have any questions on how to complete this Form W-9, please contact Maria Tavares at (401) 459-4645.

If Applicable, **Name of Practitioner:** _____

PART I - TAXPAYER IDENTIFICATION NUMBER (TIN)

Social Security Number

- -

OR

Employer Identification Number

-

TYPE OF TAXPAYER

(Check appropriate box)

☐

Individual / Sole Proprietor. (Please provide S.S.N.)

☐

Corporation

☐

Partnership

☐

Limited Liability Company. Enter tax classification _____

☐

Other (Specify) _____

☐

Exempt payee

NAME/ADDRESS: (Please print or type.)

Name (as shown on your income tax return)

Business Name (if different from above)

Address (number, street, apt. or suite no.)

City

State

Zip Code (9 digit)

-

List account number(s) here (optional)

PART II - CERTIFICATION

I certify under penalty of perjury that:

- 1 The Tax Identification Number I have provided is correct.
- 2 I am not subject to backup withholding.
- 3 I am a U.S. person (including a U.S. resident alien).

Person completing this form/Title (Please print)

Date

Tax correspondence address:

Telephone No.
() -

City

State

Zip Code

List account number(s) here (optional)



Voluntary Termination Form

Please complete this form if you must terminate your status as a participating physician/provider. You are required by contract to submit this form 60 days in advance. Please note that it is not considered a termination if you are leaving one location and will remain a participating physician/provider at another location. In that case, please submit a Practitioner Change Form. If you have any questions or would like to obtain a Practitioner Change Form, please call the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050, or visit the Provider section of BCBSRI.com.

Date: _____ Physician/provider name: _____

Group name: _____ Practice phone number: _____

Practice contact person: _____ Practice contact e-mail address: _____

Address: _____

City: _____ State: _____ ZIP: _____

BlueCHiP Plan provider #: _____ BCBSRI Plan provider #: _____

National Provider Identifier (NPI) Type 1 provider #: _____

NPI Type 2 provider # (if applicable): _____

Effective date of termination: _____

Reason for termination: ☐ Retiring ☐ Leaving Office. Reason: _____

☐ Other (please specify): _____

****Important:** If you are a primary care physician (PCP), please provide the name of ONE physician who will assume care of your patients.

Assuming physician's name: _____

Your signature (terminating physician/provider): _____

Please fax this form to (401) 459-2099 or mail it to:

Attn: Contracting Technical Support – 00084
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, Rhode Island 02903-2699



www.bcbsri.com

500 Exchange Street • Providence, RI 02903-2699

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