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Policy Name: Provider Handling of Member Inquiries, Complaints and Appeals
Policy Number: Reference - 1
Effective Date: 10/1/04
Revision Date: Review Date: 9/1/09

Approval Signature:
Senior Medical Director
Vice President–Network Management

Policy:
Blue Cross and Blue Shield of Illinois (BCBSIL) ensures that participating providers are informed of the services available to members to request information, verbalize complaints and question appeal decisions.

Procedure:
1. The provider should direct the member to call the customer service telephone number identified on the back of the member’s identification card, for the following reasons:
   a) benefit information
   b) verification of coverage
   c) information about BCBSIL
   d) information regarding the status of a claim
2. If the member is dissatisfied with:
   a) his/her medical care, or
   b) the decision(s) of BCBSIL
   the provider should direct the member to call the customer service telephone number identified on the back of the member’s identification card to initiate the review/appeal process.
3. At any time during this process, the member may request in writing that the provider or an authorized representative act on the member’s behalf.
4. During the course of the appeals process the provider may be requested to submit clinical care documentation (i.e., medical records).

Should you have questions or concerns about this policy, please contact the Provider Telecommunications Center at (800) 972-8088 or your Provider Network Consultant.
Policy:

BlueChoice Providers are required to notify Blue Cross and Blue Shield of Illinois (BCBSIL) in a timely manner of all Medical and/or Surgical services scheduled or performed.

Purpose:

- To ensure that members receive maximum benefits for services performed.
- To ensure that members receive medically necessary care delivered in an appropriate setting and on a timely basis.
- To ensure that such care is delivered by BlueChoice Providers.

Guidelines:

- No Referral forms are required for BlueChoice Select members.
- When BlueChoice members are referred to receive treatment from another physician, hospital or facility, every effort must be made to refer to an in-network participating BlueChoice provider for members to receive the highest level of benefits.
- Use the Provider Finder located at www.bcbsil.com to locate BlueChoice providers.
- BCBSIL notification of some designated services requires notification to the Medical Management department. The services which require precertification are described below.
- BCBSIL must be notified of all services requiring precertification, for which it will be billed, regardless if BCBSIL is the primary or secondary payer.
- For non-network or out-of-state inpatient admissions, precertification is the member’s responsibility.

Procedure:

A. Medical Management Notification Procedure
   1. BlueChoice Providers are responsible for contacting Medical Management for all in network services which require Medical Management’s certification.

   2. BCBSIL must be notified within the timeframe of one day prior to the admission / two days following emergency admission.
      Exception: Human organ transplants must be certified and benefits verified during the initial planning phase. Where this is not possible due to the emergency nature of such services, the provider must notify Medical Management within two business days of an emergency admission.
3. Services Which Must Be Precertified with Medical Management:
   a. Inpatient Admission
   b. Coordinated Home Care
   c. Private Duty Nursing
   d. Skilled Nursing Facility Admission
   e. Inpatient Rehabilitation
   f. Human Organ Transplants

4. When services require Medical Management notification, the following information will be collected:
   a. Patient Identifiers (Name, Group/ID #, Address and Phone Number)
   b. Admitting/Performing Provider Name
   c. Hospital/Facility Name and City
   d. Diagnosis(es)
   e. Procedure(s) or Service(s) scheduled
   f. Procedure date or Service initiation date
   g. Requested length of stay (LOS) in days (Inpatient)
   h. Requested number of units and duration of services (Outpatient)
   i. Anticipated discharge plans such as home health services, or continued care in a sub acute or skilled nursing facility

5. Initial certification will only be made after assessment against BCBSIL’s criteria. (For medical necessity, appropriateness review, and length of stay criteria used by BCBSIL see Utilization Management 8-Criteria for Appropriateness of Medical Services.) Certification will be verbally communicated to the Attending Provider and verified in writing to the PCP, PSP, patient and facility as applicable.

6. Inpatient admissions or other services that will continue over a period of days will be reviewed by Medical Management on a concurrent basis. Additional inpatient days or units of outpatient services will be certified as indicated by medical necessity criteria used by BCBSIL. All contracted providers are required to participate in the concurrent review process and to promptly communicate clinical information substantiating the need for continuing services when requested by BCBSIL.

7. Discharge planning may be initiated at any point in the services. All contracted providers are required to participate fully in the coordination of care activities performed for discharge planning.

8. If BCBSIL is notified after inpatient discharge or the services have been performed, a medical necessity review will be conducted, and a retrospective decision made to certify or deny the services. All contracted providers are required to promptly communicate clinical information substantiating the need for the services rendered upon request by BCBSIL.

9. BCBSIL requires notification of elective or emergency/urgent services to be made to Medical Management by calling the telephone number found on the back of member’s Id Card. Notification is to be made within the following time frames:
   • Elective Services: One day prior to an elective admission.
• Emergency Services: Same day notification is required where possible. In all cases, Medical Management must be notified within two business days of the services being ordered.

10. Medical Management hours of operation are 7:30 a.m. to 5:30 p.m. (CST) Monday through Friday. At all other times, including Saturday and Sunday an answering service is available to take messages. Note: the answering service does not cover on holidays. Answering service personnel are not authorized to approve services.

11. Messages left with the answering service will be responded to by Medical Management. Return calls are generally made on the same business day or, when messages are left “after-hours”, on the next business day.

Should you have questions or concerns about this policy, please contact the Provider Telecommunications Center at (800) 972-8088 or your Provider Network Consultant.
Policy:BlueChoice and BlueChoice Select Primary Care Physicians (PCPs) and Participating Specialist Physicians (PSPs) may utilize any independent Blue Cross and Blue Shield of Illinois (BCBSIL) PPO contracted laboratory. A listing of PPO contracted labs can be found on our BCBSIL Provider Finder® located at www.bcbsil.com.

Purpose:
To ensure that members receive clinically appropriate, cost effective laboratory services.

Guidelines:

- A BlueChoice referral form is not required for any laboratory services.
- Utilize any independent (BCBSIL) PPO contracted laboratory.

Procedure:
The physician may utilize any independent BCBSIL PPO contracted laboratory. Reimbursement to BlueChoice contracted physicians for laboratory services will be based on the BlueChoice Schedule of Maximum Allowances. Providers can download a Fee Schedule Request Form to request reimbursement. The form is located on the BCBSIL Provider Web site at www.bcbsil.com/provider/forms.htm.

If a venipuncture (CPT 36415) is performed, the physician may submit a claim.

Should you have questions or concerns regarding this policy, please contact the Provider Telecommunications Center (PTC) at (800) 972-8088 or your Provider Network Consultant.
Policy Name: Participating Certified Nurse Midwife (PCNM)
Policy Number: Reference - 4
Effective Date: 10/1/04
Revision Date: Review Date: 11/1/09

Approval Signature:

Senior Medical Director

Vice President–Network Management

BlueChoice, BlueChoice Select  Replaces BC Ref 2 Participating Certified Nurse Midwife (PCNM)

Policy:

A Participating Certified Nurse Midwife (PCNM) may function in the capacity of a BlueChoice or BlueChoice Select Obstetric and Gynecologic (OB/GYN) physician within the scope of the Certified Nurse Midwife license.

Purpose:

To offer BlueChoice and BlueChoice Select members the option of obtaining in-network OB/GYN services from a Participating Certified Nurse Midwife.

Procedure:

1. The PCNM must adhere to all of the BlueChoice/BlueChoice Select policies and procedures.
2. A PCNM must have an agreement for backup coverage with a contracted BlueChoice OB/GYN physician. If the BlueChoice or BlueChoice Select OB/GYN physician leaves the Network, the Nurse Midwife must obtain a new agreement for backup coverage with another contracted BlueChoice or BlueChoice Select OB/GYN in order to remain in the Network.
3. For physician services outside the scope of the PCNM’s licensure, care must be directed to the BlueChoice or BlueChoice Select OB/GYN with whom the PCNM has an agreement.
4. The PCNM is expected to participate in the utilization and quality management programs of BlueChoice or BlueChoice Select through such activities as:
   - practicing in accordance with clinical guidelines;
   - assisting in the development of clinical guidelines, if requested;
   - working to achieve BlueChoice or BlueChoice Select quality and cost goals;
   - participating in review activities, if requested;
   - obtaining precertification for hospital admissions. Refer to the Health Care Management Reference policy, Plan Notification of Medical/Surgical Services.

Should you have questions or concerns about this policy, please contact the Provider Telecommunications Center (PTC) at (800) 972-8088 or your Provider Network Consultant.
Policy:  
To ensure that BlueChoice and BlueChoice Select Providers maintain the minimal levels of professional liability insurance protection.

Purpose:  
BlueChoice and BlueChoice Select Providers are required to maintain a valid and current policy (or policies) of professional liability insurance with defined limits.

Procedure:  
1. The BlueChoice and BlueChoice Select Providers shall maintain a valid current policy (or policies) of insurance covering professional liability of the Provider, his/her agents and employees, in an amount not less than $1,000,000 per claim and $3,000,000 annual aggregate coverage. Such coverage levels will meet Blue Cross and Blue Shield of Illinois credentialing requirements.

2. The Indiana Patient’s Compensation Fund pursuant to Indiana Code 16-9.5 et. seq. regulates the amount of professional liability insurance which must be carried by Indiana physicians. Therefore, BlueChoice and BlueChoice Select Providers practicing in Indiana will maintain a valid current policy (or policies) or insurance in at least the minimum amounts required under the Indiana Patient’s Compensation Fund pursuant to Indiana Code 16-9.5 et. seq. and in all other respects qualifies for the said Indiana Patient’s Compensation Fund.

Should you have questions or concerns about this policy, please contact the Provider Telecommunications Center (PTC) at (800) 972-8088 or your Provider Network Consultant.
Policy Name: Telephone Consultations
Policy Number: Reference - 7
Effective Date: 10/1/04
Revision Date: Review Date: 11/1/09

Senior Medical Director
Vice President–Network Management
BlueChoice, BlueChoice Select
Replaces BC Ref. 9 Telephone Consultations
Approved QI: 11/4/09
Approved P&P: 10/29/09

Policy:
Telephone consultations are part of office visit services and cannot be billed separately.

Purpose:
To ensure that members receive telephone consultation within existing benefits.

Procedure:
1. Members requesting services, information, or advice may call in advance, in lieu of, or subsequent to an office visit. The BlueChoice and BlueChoice Select physician may provide consultation, information, or advice over the phone as clinically appropriate, or may direct the member to come in for an office visit.

2. Services provided in the office may be billed using the appropriate CPT code.

3. Services provided by telephone are considered part of the office-based care. They cannot be billed separately and the member cannot be billed directly for them.

Should you have questions or concerns about this policy, please contact the Provider Telecommunications Center (PTC) at (800) 972-8088 or your Provider Network Consultant.
Policy:

Blue Cross and Blue Shield of Illinois (BCBSIL) will certify only medically necessary services, as determined by use of the BCBSIL’s criteria, which are rendered in the most appropriate setting for such services.

Purpose:

To provide a process for communicating to providers and members BCBSIL’s decision to Non-Certify requests for medical services.

Procedure:

1. UM Decision-making is based only on appropriateness of care and service.
2. BlueChoice and BlueChoice Select do not specifically reward practitioners or others conducting UM for issuing Non-Certifications of coverage or service.
3. BlueChoice and BlueChoice Select do not encourage inappropriate underutilization (or Non-Certifications) through financial incentives.
4. A decision to Non-Certify requests for medical services will be verbally communicated to the Attending/Performing provider and facility within one business day of the decision for elective services and on a same day basis for emergency, urgent, or ongoing services. Written confirmation of the Non-Certification decision will be sent to the Attending/Performing provider, facility and member.
5. Decisions to Non-Certify requests for medical services can only be made by a physician member of BCBSIL’s medical staff. Decisions to Non-Certify requests for medical services will be made only after all reasonable attempts are made to discuss the case with the Attending/Performing provider. Non-Certification decisions may be appealed. (See policy – Administrative and Departicipation Appeal Process for BlueChoice Network Providers).

Should you have questions or concerns about this policy, please contact the Provider Telecommunications Center at 1-800-972-8088 or your Provider Network Consultant.
Case Management (CM) Services are available for PPO, BlueChoice Select members.

To facilitate the delivery of clinically appropriate care resulting in optimal outcomes through cost-effective services to members with chronic, complex or catastrophic disorders requiring coordination of care across multiple provider disciplines and settings.

**Procedure:**

I. CM Referral:

CM Referrals may originate from a member, Primary Care Physician (PCP)/Participating Specialist Physician (PSP), employer or Hospital Discharge Planner, Integrative Predictive Modeling, Disease Management /Wellness/Condition Management, Utilization Management, an Account Executive, Private Duty Nurse or other provider of services may request the assistance of CM. (Refer to Attachment 1), CM Trigger List, for conditions frequently referred to CM.

II. Case Management Responsibility:

a. Obtain consent for CM services and send a CM Introductory Letter.

b. Inform the member of the CM role and member’s rights and responsibility.

c. Notify the Provider that a case has been opened for their patient and will obtain the Plan of Treatment from the Provider.

d. Obtain necessary information to make an assessment of medical, psychosocial and benefit issues.

e. Use a collaborative approach with the Providers and Member/Family to develop a CM Plan.

f. Work in a collaborative manner with the Member/Family, Provider, and all other parties necessary to obtain clinically appropriate outcomes.


g. Implement the CM plan through coordination of services.

h. Evaluate and monitor the plan to achieve the desired results.

Should you have questions or concerns about this policy, please contact a Case Manager by calling 1-888-978-9034.
These are target triggers for possible case management services based not solely on the condition but also on the need and use of resources. Diagnoses that will automatically route to CM have been indicated below with a designation of Auto Route. Those with a designation of Manual are those in which a separate CM case needs to be set up.

Medical/Surgical:
- Multiple admissions – 3 unplanned inpatient admission within 6 months for the same or related condition (exclude scheduled chemotherapy) (Manual)
- Transplants (Auto Route)
- TBI (Auto Route)
- Severe Multiple Trauma (MVA) (Auto Route)
- New Paraplegia or Quadriplegia (Auto Route)
- CVA or Subarachnoid hemorrhage with residual hemiparesis/hemiplegia with functional or cognitive deficits (Auto Route)
- Diabetic with newly diagnosed Renal Failure (Manual)
- Diabetic with new amputation (Manual)
- Complicated wound management (exclude uncomplicated surgical wound) (Manual)
- End of life (Manual)
- Burns with a severity of 2nd degree and higher with a total body burn of > 20% in adults & > 10% in children under eighteen (18) years of age (Manual)
- HIV/AIDS/ARC (auto-route code of 042)
- Amyotrophic Lateral Sclerosis – ALS (Manual)

Obstetrics:
- Eclampsia (pre-eclampsia <36 wks gestation and post delivery) (Auto Route)
- Multiple gestation (Auto Route)
- Pre-term Labor (Auto Route)
- Premature Rupture of Membranes (PROM) > 23 weeks gestation (Auto Route)
- Threatened Abortion (Auto Route)
- Gestational Diabetes (Auto Route)
- HELLP Syndrome (Auto Route)
- Placenta Previa or Abruptio (Auto Route)
- Vaginal Bleeding after 23 weeks gestation (Auto Route)
- Incompetent Cervix (Auto Route)
- Hyperemesis after initial inpatient admission or with home IVF (Auto Route)
- Request for Home Uterine Monitoring or Pumps (Terbutaline, Reglan, Zofran) (Manual)
- Age <14 yrs or > 40 yrs old (Auto Route)
- Substance Abuse (Manual)

Neonates:
- Gestational age <32 wks (Manual)
- Requiring complicated discharge planning (Manual)
- Dx of diaphragmatic hernia, gastroschisis, and/or tracheo-esophageal fistula (Manual)

Miscellaneous:
- FEP Only – SNF admissions (Manual)
- Private Duty Nursing (Manual)
- Cases identified through Predictive Modeling
- Employer Group Request (Manual)
- High Dollar Cases >$50,000 (Manual)
- RX data: (Manual)
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1. IVIG
2. Avenox
3. Remicade
4. Betaseron

- Based on Market Variations (i.e.: Transportation- Air Ambulance)
- Septicemia/Bacteremia with LOS > 20 days. (Manual)
- Any cases where CM involvement may be of benefit (Manual)
- Medicare D (TX and NM only)
- Disability (TX only)