The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) have established a voluntary automatic approval process to pay claims. This voluntary agreement is between the Independent Physician Association (IPA), participating hospital and the HMOs of BCBSIL (attached).

**Purpose/Objectives:**

- To allow appropriate group approved services performed at hospitals to be automatically processed electronically through the HMO claims processing system.
- To reduce the volume of paper claims.
- To increase electronic submissions by the hospitals to BCBSIL while also reducing the delay in claims processing by eliminating the need to send claims to the IPA for approval.

**Procedure:**

1. IPA will log and provide to the Hospital a list in an agreeable format, of all group approved hospital admissions and outpatient surgeries.
2. If an appropriate service is on the IPA log, when submitting the UB04, the hospital will input into the Source of Admission Field (15), a value 3 for HMO Referral or a value 7 for Emergency Room Related. In addition, the hospital will also input the word “GAP” (Group Approval Process) into the Treatment Authorization field (63). This indicates that the claim is “Group Approved” and will be adjudicated accordingly.
3. If the appropriate service is not on the IPA log, the hospital will leave field number 63 blank. These claims will be sent back to the IPA for approval/non-approval status.
4. If the hospital places “GAP” on the claim form in error for services that are not group approved all parties agree that the:
   a. IPA is responsible to identify errors.
   b. IPA will notify the Hospital of the error.
   c. The Hospital will refund the claim payment to the HMO within 14 calendar days of notification by the IPA to the hospital.
   d. HMO will review the claim under the appropriate guidelines for the specified time period. If the claim cannot be paid, the approval code is changed to Not Group Approved and an Explanation of Benefits is generated to the Member indicating the claim was denied.
AUTOMATIC APPROVAL AGREEMENT

THIS AGREEMENT is made and entered into this __________________________, 200_ by and between Health Care Service Corporation, a Mutual Legal Reserve Company, d/b/a HMO Illinois and ___________________________________________, and ___________________________________________, a duly constituted medical group Individual Practice Association ("IPA").

WHEREAS, HCSC and Hospital have entered into a Hospital Service Agreement where under among other things, Hospital agreed to provide hospital services to persons covered under the health maintenance organization ("HMO") benefit programs issued or administered by HCSC ("Covered Persons"); and,

WHEREAS, HCSC and IPA have entered into a Medical Service Agreement ("MSA") where under among other things, IPA agreed to provide professional physician and ancillary services to Covered Persons, including, but not limited to ordering or approving hospital admissions for necessary hospital services; and,

WHEREAS, Claim Payments by HCSC for hospital services are contingent upon such order or approval by IPA; and

WHEREAS, the parties desire to develop a procedure for the automatic transmission of IPA order and approval status for Covered Persons.

NOW, THEREFORE, in consideration of these promises and agreements hereinafter set forth, the parties hereby agree as follows:

1. During the term of this Agreement, IPA shall provide to Hospital on a daily or weekly basis a written list in a format agreed upon by IPA and Hospital identifying Covered Persons for whom IPA has ordered or approved hospital admissions/ambulatory or out-patient surgery for the preceding day or week.

2. After receipt of such list, Hospital shall submit to HCSC through Hospital's Off-Site Terminal or other electronic medium as approved by HCSC, any Claim(s) for payment of IPA ordered or approved hospital services rendered to such Covered Persons by inserting the term "GAP" in the Treatment Authorization field 63 of the UB 04 and a value 3 (HMO Referral) or a value 7 (Emergency Room) in the Source of Admission field (15) as set forth in the sample marked as Exhibit I, attached hereto and made a part hereof.

3. Within 14 days of receipt of a completed Claim, HCSC shall process the Claim and send notice of the disposition to Hospital. The Claim Payment shall be remitted by HCSC to Hospital under the terms of the Plan Hospital Contract.
4. Any errors identified in adjudicating Claims based upon incorrect IPA order or approval status will be promptly corrected by HCSC. In the event of an erroneous Claim Payment resulting from an incorrect IPA order or approval status, Hospital shall refund the Claim Payment to HCSC within 14 days of notification by the IPA to Hospital of the error.

5. This Agreement shall continue in full force and effect for one year, effective ______ and shall be renewed for successive one year periods, or such other period as mutually agreed by the parties, unless terminated as provided in this Agreement. Upon any termination, the rights and obligations of the parties shall nevertheless continue with respect to any Covered Person admitted to Hospital prior to the termination effective date.

6. This Agreement shall terminate immediately and without notice upon termination of the Plan Hospital Contract between HCSC and Hospital or upon termination of the MSA between HCSC and IPA.

7. Unless terminated as provided in paragraph six above, this Agreement may be terminated by either party at any time upon three months prior written notice to the others.

8. Each party shall indemnify the other and hold it harmless from any demands, suits, losses, liability, damages, claims, costs, expenses (including attorneys' fees and costs of defense) arising out of the fault or negligence of any employee, director, officer, or agent of the indemnifying party in connection with this Agreement or the breach by the indemnifying party of any provision of this Agreement. It is understood and agreed that no act of any person who is an independent contractor to and not under the direction of the parties to this Agreement shall give rise to any liability under this indemnification provision.

9. For purposes of this Agreement the HMO programs referenced herein shall include the product offered by HCSC's wholly-owned subsidiary, BCI HMO, Inc.

10. For purposes of this Agreement the following terms shall be defined as follows:

   (a) Claim - means notification in a form acceptable to HCSC that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished, the date of service, applicable diagnosis and the Claim Charge for such service.

   (b) Claim Charge - means the amount which appears on a Claim as the Provider's regular charge for services rendered to a patient, without further adjustment or reduction and irrespective of any separate financial arrangement between HCSC and Hospital.
(c) Claim Payment - means the benefit payment made by HCSC, upon submission of a Claim, in accordance with the benefits specified in the health maintenance organization benefit program of each Covered Person. All Claim Payments shall be calculated on the basis of the Hospital's Claim Charge for Covered Services rendered to the Covered Person, irrespective of any separate financial arrangement between HCSC and Hospital.

(d) Off-Site Terminal - means the Cathode Ray Tube ("CRT") installed in Hospital which enables Hospital to obtain direct access to limited data in HCSC's computer system.

11. HCSC, Hospital and IPA are independent contractors with respect to this Agreement, and nothing in this Agreement shall create, or be construed to create, the relationship of principal/agent and employer/employee between the parties, nor shall either parties' agents, officers or employees be considered or construed to be considered agents, officers or employees of the others for any purpose whatsoever. It is understood and agreed that nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement, including, but not limited to, Covered Persons.

12. This Agreement shall be governed, construed and enforced in accordance with the laws of the State of Illinois.

13. This Agreement may be amended by mutual agreement of the parties hereto at anytime, but, to be effective, any amendment hereto must be in writing and signed by an authorized representative of each party.

14. No civil action shall be brought to recover under this Agreement after the expiration of three years from the date the cause of action accrued.

15. No part of this Agreement or any rights, duties or obligated described herein may be assigned or delegated by either party without the written consent of the other party unless specified or permitted under this Agreement.

16. The waiver by either party of any breach of any provision of this Agreement shall not be construed as a waiver of any subsequent breach of the same or any other provision.

The failure to exercise any right hereunder shall not operate as a waiver of such right. All rights and remedies provided for herein are cumulative.
17. All notices, directions or requests under this Agreement, other than routine correspondence, shall be in writing and shall either be delivered or mailed, Certified or Registered Mail, to the other addressed as follows or as otherwise designated in writing:

If to HCSC:

Heath Care Service Corporation,
a Mutual Legal Reserve Company
300 East Randolph
Chicago, Illinois 60601-5655

Attention: Steve Hamman 25th Floor

If to Hospital:

_____________________________________
_____________________________________
_____________________________________

Attention: ______________________________

If to IPA:

_____________________________________
_____________________________________
_____________________________________

Attention: ______________________________

This Agreement constitutes the entire understandings of the parties hereto. Any prior agreements, documents, understandings or representation relating to the subject matter of this Agreement and not expressly set forth herein or referred to or incorporated herein by reference are of no force and effect.
IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year first above written.

HEALTH CARE SERVICE CORPORATION, a Mutual Legal Reserve Company

HOSPITAL

By: ___________________________ By: __________________________

Title: __________________________ Title: __________________________

Date: __________________________ Date: __________________________

Witness: ________________________ Witness: ________________________

IPA

By: ______________________________

Title: ______________________________

Date: ______________________________

Witness: ______________________________

Reviewed 10/1/09
Policy:

The HMOs of Blue Cross and Blue Shield of Illinois will electronically provide the Independent Physician Associations (IPA) with a daily report that will require the IPA to notify the HMO of the group approval status of all claims that are the financial risk of the HMO.

Purpose/Objectives:

- To enhance timeliness and efficiency in processing claims that are the financial risk of the HMO.
- To improve provider and member satisfaction by promptly paying claims.
- To improve member satisfaction by reducing billing and collection notices.
- To allow the IPA the ability to assume financial risk.

Procedure:

1. Provider will submit claims either electronically or on paper to the HMO for processing.

2. The HMO will process HMO facility claims for payment that have been electronically submitted on the UB04 form. The HMO verifies that it is submitted with the Automatic Group Approved (GAP) code whereby “GAP” must be entered in the Treatment Authorization field (63). A value of 3 (HMO Referral) or 7 (Emergency Room related services) must be entered in the Source of Admission field (15). The HMO claims processing system will also read the online provider file to verify claim(s) will be processed accordingly if all criteria are met.

3. The HMO will process all ambulance claims that are less than or equal to $1,000.00 as Group Approved.

4. All remaining claims will be listed on the Internet 095 Report.

5. The IPA is required to respond within 14 calendar days to the 095 Report by checking the appropriate box for each claim listed. Guidelines for determining group approval status:

   [ ] GA – Group Approved
   Claim is group approved, services were rendered by or referred by a Primary Care Physician (PCP) or Participating Specialist Provider (PSP) affiliated with the IPA. The services are considered group approved if the member presented as an HMO member regardless of membership status.
[ ] NGA - Not Group Approved
Claim is not group approved, member was not treated by or referred by a PCP or PSP affiliated with the IPA.

[ ] MGR - Med Group Risk
Claim is group approved and is the financial risk of the HMO but the IPA has made the determination to pay the provider.

NOTE: The HMO will not provide a copy of the claim. If an IPA risk claim appears on the 095 Report, check GA or NGA and in the comment field indicating the claim is IPA risk.

If the IPA assumes liability, the following rules apply:
1. The IPA must pay according to the rules of Prompt Pay.
2. No units will be charged on the Utilization Management (UM) Fund.
3. The claim cannot be submitted for reinsurance.
4. If a member calls the HMO after 45 days from the response to the 095 Report stating the claim remains unpaid, the HMO will contact the provider. If the bill is unpaid, the HMO will pay the claim. Units will be charged and the IPA forfeits the right to challenge the UM Fund.

6. The HMO will process the claims according to the status provided by the IPA.

7. If the IPA fails to respond within fourteen calendar days, the claims will default to a status of Group Approved and the HMO will process the outstanding claims.
   a. Appropriate units will be charged against the IPA's UM Fund.
   b. Challenges to the UM Fund on claims that the IPA failed to respond to will be denied.
   c. All claims related to that date of service that are the IPA's financial risk will also default to Group approved status and the IPA will be required to pay all related services.
Policy:

The HMOs of Blue Cross and Blue Shield of Illinois will pay eligible charges on claims that are the Independent Physician Association’s (IPAs) risk to pay if the claim has not been appropriately processed by the IPA.

Purpose/Objectives:

- To enhance timeliness and efficiency when processing claims that is the IPA’s financial risk.
- To improve member satisfaction by promptly processing claims and eliminating service related issues.
- To improve communication between the HMOs and the IPAs.

Guidelines:

The following criteria must be met to process a claim as a Past Due Claim (PDC):

1. Membership Status:
   - The member must have been assigned to a valid IPA at the time services were rendered.

2. Bill or Statement Received by Member:
   - The claim needs to be processed on HMO claim system and forwarded to the correct IPA more than 45 days or,
   - The claim is more than 120 days old from date of service or,
   - The claim is currently in collection status.

3. Statement Status:
   - The date of service should be more than 45 days and,
   - The claim in question should have a statement date that is less than 30 days old.

Procedure:

1. An HMO Member or a representative from the HMO marketing office acting on behalf of the member contacts the Full Service Unit (FSU) office regarding an unpaid bill that is the financial risk of the IPA.

2. The Customer Advocate (CA) verifies claim history to ensure that the claim was adjudicated correctly.

3. If review of claim history shows no claim payment or denial, CA should initiate the web based PDC process.
4. The IPA has 10 calendar days to respond via web based PDC program with a valid response whereby acceptable valid responses include:

   a. Paid by site with check number/capped payment without check number (if capped then check number not needed),
   b. Paid-indicating a future paid date with check number/capitation payment date. If a check number is not available, mark ‘other’ box indicating in comments field the future paid date. The paid date must be within 14 calendar days of the PDC due date,
   c. Denied for timely filing,
   d. Denied for no authorization,
   e. Group Approved HMO risk to pay,
   f. Other…. then comments must explain.

**Note: If check date, capitated date, denied date or write off date is more than 30 days old, please enter the date provider was contacted to resolve the payment issue.

5. If an IPA submits a claim on the web with an incorrect response, the IPA can follow the procedure;

   a. Open the claim in question on the web.
   b. Make a screen print from the detail page that shows the status.
   c. Write directly on the screen print the corrected status.
   d. Explain the reason for the change in status.
   e. Print your name and the name of the IPA.
   f. Fax to 815/639-7104.

   Note: All changes must be submitted within 24 hours from the IPA’s original response to the PDC.

6. IPAs requesting a copy of the claim(s) can do so via e-mail. On the subject line of the e-mail, include the HMO IPA site number and in the body of the e-mail, list the IPA fax number. Using the HIPAA compliant encryption (PHI), IPAs can send requests to the following e-mail address:

   HMOIclaimrequests@bcbsil.com

7. If an invalid response is received, claims are paid and deducted from capitation, the appropriate internal areas are notified and a monthly report is sent electronically to the IPAs.

8. All capitation deductions will be posted on the monthly capitation summary report.

9. If the provider refunds HMO as a result of a duplicate payment HMO will automatically refund to the IPA via capitation check the amount the provider refunded to HMO.

10. If the IPAs feel deductions are inappropriate, they have the right to challenge the PDC deductions.

   All challenges must be on an appropriate PDC challenge form located on the web site and should be faxed or mailed to CA within 60 calendar days of deductions.

**Capitation Deduction Process**

1. The Health Care Management Business Systems Analyst will run the PDC report by IPA on the tenth of each month to identify all claims paid as a PDC from the previous month.
1. The Financial Analyst will generate a report and process adjustments on the next capitation check.

2. The capitation check summary will show the total PDC deduction for all members for all claims paid in the previous period. The PDC report detailing the monthly capitation deductions by member will be sent to the IPA prior to receipt of the capitation check.

IPA Challenge

1. The IPA may challenge the PDC deduction by submitting proof that a valid response was provided to the PDC notice within the allotted 10 days. The challenge should include:
   a. The IRIS confirmation number or a copy of the web page PDC response or,
   b. The challenge should be submitted in writing within 60 calendar days of the capitation deduction to the FSU office.

2. The FSU office will review the challenge and provide a written response to the IPA within 30 calendar days of receipt of the written challenge.

3. If the FSU office concurs with the IPA and the IPA has submitted proof of payment, the FSU office will request a refund from the provider. The IPA will be reimbursed upon receipt of the refund. If the deduction was made due to an HMO processing error, the IPA will receive a refund prior to the provider reimbursing the HMO.

4. If the services were non-group approved, then the FSU office will review for Life Threatening Emergency (LTE) guidelines. If LTE is not met the FSU office will request a refund and send an Explanation of Benefits to the member.

5. If the FSU office does not concur with the challenge, FSU will provide a written explanation to the IPA within 30 calendar days.
HMO Past Due Claims (PDC) Appeal Form
(Form must be filled out completely to be considered for appeal)

Date: ________________    IPA #: ________________
Group #: ______________   SSNI: _________________

Member Name:______________________________________________

Date of Service: __________   Amount Billed:______________

Provider Name: ____________________________    HMO Claim #:______________________________

Did you receive the PDC notice? YES     NO
(Must circle Yes or No)

Did you respond to the PDC notice? YES     NO
(If yes, must provide web PDC response)

(Section below must be completed to receive cap reimbursement if appeal is approved)

_____ Provider capitated on _________. Provider was called on ________ and was instructed not to
    bill member again. (Provide dates in spaces above)

_____ Stale dated claim. Provider called on ________ and was instructed not to bill member again.

_____ Claim paid on _________ with check (voucher) # _____________.

_____ Claim paid at a future date on _______________ with check # __________________ or
    Mark ‘other’ and indicate in comment field future paid date.

_____ Claim is Not Group Approved

Other

**********************************************************************************

Reply Section
To Be Completed by the HMO

Appeal Approved: _________    Appeal Denied: ________

Explanation: ________________________________________________________________

Complete By:_______________    Date Completed: __________

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
Policy Name: HMO Administered Complaints  
Policy Number: Administrative-39  
Effective Date: 7/1/99  
Revised Date: Review Date: 1/1/10

Policy:
The HMOs of Blue Cross and Blue Shield of Illinois will issue an HMO Administered Complaint to the Independent Physicians Association (IPA) if the IPA fails to adhere to the HMOI Policies and Procedures requirements as specified in the Medical Service Agreement (MSA).

Purpose/Objectives:
- To ensure that IPAs comply with the requirements as specified in the MSA.
- To provide a consistent mechanism for assigning HMO Administered Complaints to the IPAs for failure to adhere to terms of the MSA which may include but are not limited to:
  - Administrative
  - Access to Care
  - Quality of Care
  - Failure to Pay

Guidelines:
The following guidelines will be followed to determine when an HMO Administered Complaint should be issued in each of the following categories:

1. Administrative:
   a. IPA has failed to respond to HMO inquiries within 14 calendar days.
   b. IPA has failed to respond to Illinois Department of Insurance and/or Attorney General cases within seven calendar days.
   c. Failure to submit required information within designated timeframes.

2. Access to Care:
   HMO administrative staff determines that the IPA has failed to adhere to the following access standards:
   - Comprehensive exam within four weeks of request;
   - Routine appointments within 10 business days or two weeks of request, whichever is sooner;
   - Urgent appointments within 24 hours of request;
   - Non-urgent symptomatic appointments within four calendar days of request;
   - Evening or early morning office hours three or more times per week;
   - Weekend office hours two or more times per month;
   - Response by IPA physicians within 30 minutes of an emergency call
   - Notification to the member when the anticipated office wait time for a scheduled appointment may exceed 30 minutes,
HMO Administered Complaints
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- Maintain a 24-hour answering service and assure that each PCP and WPHCP provides a 24-hour answering arrangement, including a 24-hour on-call PCP arrangement for all Members.
- Assure that all IPA physicians inform the member of treatment options

3. Quality of Care:

When the HMO receives a complaint about the Quality of Care of clinical services provided by the IPA or one of their contracted physicians, the complaint will be forwarded to one of the HMO Medical Directors who will review the complaint in accordance with the Quality of Care Complaint Policy.

Quality of Care issues may be related to clinical care or clinical services provided by a physician, IPA or other medical facility.

Each complaint is assigned a severity level based on the classification of the Quality of Care complaint. These are as follows:

- 0 - No quality issue.
- 1 - Minor issue, communication problem.
- 2 - Quality issue, patient outcome not affected adversely.
- 3 - Quality issue, patient outcome affected adversely.

An HMO Administered complaint is issued for any Quality of Care inquiry determined to be either severity level 2 or severity level 3.

4. Failure to Pay:

A Failure to Pay Complaint will be issued by the HMO in the following circumstances;

- IPA has failed to pay a group-approved claim, which is their financial responsibility, within 30 days after receipt, as stated in the MSA. The HMO may elect to pay the claim and deduct funds from the IPA's capitation or other sources of earned funds.
- IPA has acknowledged prior receipt of a claim, and the claim has not been paid. IPA does not pay claim within 14 calendar days of notification by the HMO.
- IPA originally denied a claim as 'Not Group Approved', and then later determined it to be 'Group Approved'. IPA is not allowed an additional 30 days to pay. Claim must be paid within 14 calendar days from the date the IPA is notified by the HMO, or an HMO Administered Complaint will be issued.
- If the IPA states a claim is/will be paid and the HMO receives another inquiry 30 days or more after said paid date, and the HMO confirms the claim is still not paid, the HMO will exercise its right to pay the claim, deduct funds from the IPA's monthly capitation, and issue two HMO Complaints against the IPA.
Procedure:

1. Fax an IPA response letter with a copy of the inquirer’s complaint to the IPA requesting a response within 14 calendar days from the date of the letter.

2. If there is no response within 14 calendar days, the Health Service Assistant (HSA) follows up with the IPA via a phone call. The IPA is asked for a specific date when they will fax or call with the requested information. An extension will be granted for extenuating circumstances as determined by BCBSI HMO to those MGs/IPAs who have requested additional time to do further investigation.

   Extenuating Circumstances Include:
   - Response is needed from physician and he/she is on vacation/ill.
   - Medical records are needed.
   - Further investigation is needed to determine approval status.

3. If there is still no response or the IPA does not respond by the given date, a written 10-Day Notice to the IPA is issued. A copy of the notice and inquiry is given to the Provider Network Consultant the same day it is sent. The Internal Provider Network Consultant will intervene with the IPA within five working days.

4. If a 10-Day Notice is sent, a “HMO Administered Complaint” is issued. The complaint is addressed to the administrator of the IPA. Copies are also distributed to the appropriate BCBSI HMOs’ staff.

5. If there is no resolution to the 10-Day Notice by the IPA within the 14 calendar day period, and the inquiry is a claim issue, the claim is paid and deducted from capitation.

6. A “Failure to Pay” complaint is issued.

7. If the inquiry is an IPA complaint other than a claim issue (i.e., problem with office staff), the HSA pends the inquiry. Inquiry is given to the Internal Provider Network Consultant for final resolution.

8. The Internal Provider Network Consultant will provide a written response to the HSA within 14 calendar days and the IRIS file is updated with the final resolution and member notification is sent.

9. A Quality of Care Complaint is investigated in accordance with the Quality of Care Policy and Procedure. An HMO Administered Complaint is issued when the complaint is assigned a severity Level of 2 or 3.

10. Failure to submit requested information within specified timeframes.

Reporting

1. The attached HMO Administered Complaint form should be completed and the appropriate HMO staff receives a copy. (see attached)

2. A copy of the HMO Administered Complaint form is sent to each IPA, when issued, for the purpose of giving feedback to the IPA on their performance.

3. A Monthly HMO Complaint Report is generated by the Report staff and distributed to Management and Provider Network Consultants that provides data on the number of HMO Complaints issued during the month. The HMO Complaints are compared to the average membership during the month, and the number of HMO Complaints per 1,000 members per year is reported. Monthly data is used to determine the Quality Improvement Fund.

4. The HMO Provider Network Consultant will review detailed reports on each HMO Administered Complaint with the IPA on an as-needed basis to identify aberrant behavior with IPA.
HMO Administered Complaints
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___________________(Date)
___________________(IPA)
___________________(IPA Administrator)
___________________(City/State/Zip)

RE: ___________ (Member)
____________(ID#)
Case #: __________

Dear___________________(IPA Administrator):

The following inquiry has been determined to be an "HMO Administered Complaint" for purposes of
the Service Provision of the Medical Service Agreement.

Category of Complaint

☒ Administrative: 

☒ Access to Care: 

☒ Quality of Care: 

☒ Failure to Pay: 

Please report this action to your Peer Review Committee so they are aware of the problem.

Sincerely,

_____________________
Health Services Assistant

cc: Executive Director
    Director
    Provider Relations Manager
    HMO Provider Network Consultant
    Customer Assistance Unit Manager
    Customer Assistance Unit Supervisor
    Report Supervisor
**HMO Policy and Procedure**

**Policy Name:** Member Inquiries and Complaints  
**Policy Number:** Administrative-27  
**Effective Date:** 4/1/96  
**Revision Date:** Review Date: 3/1/10

**Approval**  
**Signature:**  
Senior Medical Director  
Vice President–Network Management

**POLICY:**

The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) will adjudicate inquiries and complaints in a manner which is thorough, appropriate, efficient and timely.

**PURPOSE:**

The purpose of this policy is to ensure timely resolution of member inquiries and complaints. The specific objectives are:

- To ensure timely resolution to the member/inquirer’s request for information or review
- To ensure timely response to the member/inquirer
- To ensure follow-up by the HMO on unresolved issues
- To ensure compliance with legislative mandates

**DEFINITIONS:**

1. An inquiry is a general request for information regarding claim, benefit or membership information. These inquiries either are received via phone call or paper media from various sources. Inquiries include, but are not limited to, the following: benefits, policies and procedures, enrollment, or claims processing.

2. A complaint is an expression of dissatisfaction, either oral or written. Complaints include but are not limited to the following: claim related issues, membership, group billing, Independent Physician Associations (IPA), Primary Care Practitioners, other providers, agency benefits, quality of care and HMO employees (service related).

   An adverse benefit determination may initiate a DOL/ERISA appeal based on the guidelines for appeals, however, may qualify as a complaint in the coding process for Inquiry Reporting System files.

A DOL/ERISA appeal is a request for reconsideration of an adverse benefit determination. Appeals are received either via telephone or written media. Appeals include but are not limited to, claim related issues and benefits.
HMO PROCEDURES:

To inquire, complain or appeal to the HMO, members can either call or write.

**Phone Call Inquiries or Complaints**

1. Members can call 1-800-892-2803 and the HMO network phone router will allow them to select the proper area for processing as follows:
   - Provider/IPA inquiries,
   - Member address changes, ID card requests
   - Prescription drug information, and
   - All other callers

2. Calls are routed to the appropriate area for processing within the Member Services Unit. (Translation services are available in multiple languages)

3. All Customer Advocates receiving the call will follow the same protocol:
   a) Enter the call into the Inquiry Reporting System and it will be issued a case number. The case number is used to reference the inquiry/complaint. The Inquiry Reporting System allows the Customer Advocate to also route the inquiry to another area as needed.
   b) Document the following on the beginning screens of the Inquiry Reporting System:
      - Caller’s name
      - Tone of the caller (HCM Division only)
      - Source of the call/inquiry
      - Topic should be coded as an inquiry or complaint
      - If the Inquiry is related to an adverse determination, you must code the appeal as a “Y” in addition to coding the complaint/inquiry fields

4. Membership changes on the phone are not solely limited to an address change, ID card requests and IPA changes. While the caller is on the phone, the Customer Advocate documents any changes. The changes are then forwarded to the HMO Customer Advocate that handles membership changes or the HMO Membership area, which subsequently processes the changes. The goal is to finalize those inquiries within the date requested.

5. The Customer Advocate requests specific details for proper research of files. The caller remains on the line while the Customer Advocate researches all related support files as required, based on information provided by that caller.

6. If the issue can be resolved immediately with the caller on the phone, the Customer Advocate does so and consequently closes the Inquiry Reporting System file. The Inquiry Reporting System will reflect the reason for the call and the resolution information. The closure date will indicate the date the item was finalized. (Refer to Inquiry Reporting System Standards for Inquiries, Complaints and Appeals policy)
7. If the issue cannot be resolved immediately:

- The Customer Advocate advises the caller/inquirer of the required information, documents it on the Inquiry Reporting System and follow up will be maintained until final resolution of that inquiry/complaint or until we have exhausted all means of obtaining required additional information.

- A call or a letter will be sent to the appropriate party requesting the additional information. The item will remain open until resolution is reached or until we have exhausted all means of obtaining the additional information.

- All phone inquiries and complaints should be resolved within 30 days according to standards adopted by the Blue Cross and Blue Shield Association.

8. Customer Advocates are required to routinely check status on any files in a pending status for additional information.

9. Upon receipt of additional information, the Inquiry Reporting System file is resumed and the member/inquirer is notified of the resolution. In the event the resolution of the case is not in the member’s favor, the member is notified in the resolution letter or by phone, of the right to appeal the decision to the HMO. The member is also given information on how to initiate the appeals process. Resolution notification via telephone must be documented on the Inquiry Reporting System.

10. If all information has not been received after the initial request, a status letter is generated to the member/inquirer and contact can also be made by phone. This contact explains the delay in resolving the inquiry/complaint and may also request the member/inquirer to assist with obtaining additional information. Follow up information must be documented appropriately in the Inquiry Reporting System.

11. The Inquiry Reporting System is closed once the letter requesting additional information is sent to the member/inquirer. All required supporting information will be documented in the Inquiry Reporting System. The closure date is the date the letter is sent.

   Note: Additional information could be received and processed as a regular inquiry if there is no reference to a previous inquiry case number.

Written Inquiries or Complaints

1. All items received are stamped with the corporate receipt date.

2. Items are scanned into IMAGE, routed into the various IMAGE work queues and issued an Inquiry Reporting System case number.

3. Upon receipt of a member complaint/inquiry, the member is sent an acknowledgement letter which acknowledges receipt and details of the appeal process.

4. The Customer Advocate determines if the inquiry can be appropriately handled within the department.
5. If the inquiry can be handled within the Member Services Unit
   a) The Customer Advocate follows the same protocol and time frame as a phone call inquiry or complaint. (Reference pages 2&3)

6. All inquiries being sent to other areas are placed in a pending status in the Inquiry Reporting System. Inquiry Reporting System and IMAGE documents are routed to the receiving department via IMAGE if it is available to the recipient. If unavailable then documentation will be routed via electronic mail.
   a) All prescription drug inquiries are routed to the Prescription Drug Inquiry Unit.
   b) All non-clinical and clinical appeals, quality of care issues, benefit determinations, Department of Insurance and Attorney General complaints are routed to the Customer Assistance Unit.

IPA PROCEDURES for handling Member Inquiries and Complaints

1. The HMOs of BCBSIL retain full responsibility for resolution of member complaints. Member and provider literature gives explicit instructions to our members advising them to send all complaints to the HMOs for resolution. Despite the instructions of the HMOs, a small number of members may choose to go directly to their primary care physician or selected IPA to voice inquiries or complaints.

2. In the event a contracted IPA receives a member complaint, either orally or in writing, the HMOs of Blue Cross and Blue Shield of Illinois require the IPA to respond to the member.

3. In order for the HMOs to maintain complete responsibility for complaint management, all IPAs are required to maintain a detailed log of member complaints. The HMOs in turn monitor the IPA's performance of complaint management and resolution.

4. The IPA is required to notify the member of the right to appeal to the HMO if the member is not satisfied with the resolution of their complaint.

DOL/ERISA
Telephone Complaints - qualified as DOL/ERISA Appeals

1. The Customer Advocate requests specific details for proper research of files. The caller remains on the line while the Customer Advocate researches all related support files as required, based on information provided by the caller.

2. If the issue can be resolved immediately with the caller on the phone, the Customer Advocate will provide the resolution and consequently closes the Inquiry Reporting System. The Inquiry Reporting System will reflect the reason for the call and the resolution information. The closure date will indicate the date the item was finalized.

3. If the issue cannot be resolved favorably, the caller will be advised of their appeal rights.

4. Either determination requires the DOL/ERISA indicator to be coded as a “Y”
Inquiry Reporting System Documentation for complaints qualified as DOL/ERISA Appeals

A DOL/ERISA field indicator has been added to Inquiry Reporting System screens. Appeals handled via telephone call will require the DOL/ERISA field indicator to be coded with a “Y”. The “Y” indicator must be used regardless of the outcome of the appeal.

Written Complaints - qualified as DOL/ERISA Appeals

1. All items received are stamped with the corporate receipt date.

2. Items are scanned into IMAGE, routed into the OPENI work queue and issued an Inquiry Reporting System case number.

3. The Customer Advocate determines if the inquiry can be appropriately handled within the department.

4. The appeal can be handled within the Member Services Unit, when the outcome is favorable to the member.

5. The appeal cannot be handled within the Member Service Unit when the outcome remains unfavorable to the member. Route to the Customer Assistance Unit (CAU).

DOL/ERISA Claim Modification

When DOL/ERISA appeal reviews pertain to a claim, the claim has to be modified. (Please see DOL/ERISA claim modification guidelines)

INQUIRY REPORTING SYSTEM CODING - GENERAL
Inquiries, Complaints and DOL/ERISA Appeals

<table>
<thead>
<tr>
<th>Inquiry</th>
<th>General information code as an inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint</td>
<td>Code as a complaint using complaint codes and Subcategory Codes</td>
</tr>
<tr>
<td>Complaint and DOL/ERISA Appeal</td>
<td>Codes as a complaint and use the DOL/ERISA Appeal Field</td>
</tr>
<tr>
<td>Appeal and DOL/ERISA Appeal</td>
<td>Use Appeal coding and DOL/ERISA Appeal field and route to CAU.</td>
</tr>
</tbody>
</table>
INQUIRY REPORTING SYSTEM, CODING - SPECIFIC
INQUIRIES AND COMPLAINTS

- Inquiry Reporting System coding for Inquiries should be limited to standard Inquiry codes
- Complaints should be coded with the standard Inquiry Reporting System Complaint codes
- DOL/ERISA Appeals should be coded on the Inquiry Reporting System using the standard coding for DOL/ERISA appeals

HMO COMPLAINT INQUIRY REASON CODES

- CMP = CLAIM RELATED COMPLAINT
- CMQ = MEMBERSHIP COMPLAINT
- CMR = GROUP BILLING COMPLAINT
- CMS = PROVIDER COMPLAINT
- CMT = APPEAL COMPLAINT
- CMU = AGENCY COMPLAINT
- CMV = GENERAL BENEFIT COMPLAINT
- CMW = QUALITY OF CARE COMPLAINT
- CMX = OTHER COMPLAINT
- CMY = BEHAVIORAL HEALTH COMPLAINT
- CMZ = PRESCRIPTION DRUG COMPLAINT

HMO COMPLAINT ACTION CODES

CLAIMS ISSUES
- CMA = GROUP APPROVED: HMO NOT PAYING
- CMB = GROUP APPROVED: MG NOT PAYING
- CMC = GENERAL CLAIMS ISSUE
- CMD = MEMBERS RESPONSIBILITY
- CME = APPROVAL STATUS RELATED
- CMF = HMO USA BILL NEVER RECEIVED IN HOUSE

MEMBERSHIP ISSUES
- CMG = IPA CHANGE PROBLEMS
- CMH = ID CARD RELATED (INFORMATION WRONG OR NO RELATED)
- CMI = DATA/FILE RELATED
- CMJ = GUEST MEMBERSHIP ISSUES
- ELG = ELIGIBILITY ISSUE

BILLING ISSUES
- CMK = EMPLOYER GROUP BILLING ISSUE
- CML = COBRA
- CMM = DIRECT PAY BILLING ISSUE
- CMN = MG CAPITATION ISSUE
Members Inquiries and Complaints
Page 7 of 8

PROVIDER ISSUE – NOT QUALITY OF CARE

HCA = IPA (PHYSICIANS, STAFF)
HCB = PRACTITIONER OFFICE SITE
HCC = NO PROVIDER IN AREA

FORMAL APPEAL (IN WRITING) FORMS MAILING MATERIALS

HCD = OUT OF AREA/OUT OF NETWORK
HCE = APPEAL/GRIEVANCE OF NON GROUP APPROVED SERVICE
HCF = APPEAL/GRIEVANCE OF NON COVERED BENEFIT
HCG = APPEAL/GRIEVANCE OF REFERRAL

BENEFIT ISSUE

HCH = LEVEL OF COVERAGE
HCI = DENTAL
HCJ = VISION
HCK = PRESCRIPTION DRUG/RX
HCL = HOST COVERAGE DIFFERENCE
SNC = NON-COVERED

BCBSIL ISSUES (GENERAL BENEFITS)

HCR = UNPROFESSIONAL PHONE CONDUCT (BY BCBSIL EMPLOYEE)
HCS = INACCURATE INFORMATION
HCT = UNSATISFACTORY SUBSCRIBER EDUCATION
HCU = COMPLAINT AGAINST ADMINISTRATIVE POLICY
HCV = FORMULARY/NON-FORMULARY
HCW = MAIL ORDER
HCX = CO-PAYS
HCY = PHARMACY MGMT REFERRALS
PRIVACY COMPLAINTS

1. A member or a member’s personal representative can submit a privacy complaint orally or in writing.
   a. Oral complaints - transfer to the Privacy Complaint Form or print the Inquiry Reporting System notes and attach to the Privacy Complaint Form
   b. Written complaints - attach the written complaint to the Privacy Complaint Form

2. The Full Service Unit (FSU) will forward the Privacy Complaint Form and related attachments to the Privacy Office in a confidential envelope.

3. Notify the Privacy Office via email that a complaint is being forwarded. (Email address for the internal communication is: Privacy Office)

4. Update and close the Inquiry Reporting System using appropriate codes. All privacy complaints being forwarded to the Privacy Office should be coded with Complaint code CMX and action code HCU.

5. The Privacy Office will send the member or the member’s representative a Complaint acknowledgement letter and respond to the member within a reasonable timeframe.

6. The Privacy Office must log all complaints into the Incident Tracking Database and maintain for a period of 7 years.

7. Members, or a member’s authorized representative, calling regarding the status of a pending privacy complaint, should contact the Privacy Office at 1-800-607-7418.
Policy Name: Participating IPA Appeal Process of Failed Utilization Management (UM) Adherence Audit

Policy Number: Administrative-30
Effective Date: 3/1/98
Revision Date: Review Date: 1/1/10

Policy:
The HMO’s of Blue Cross and Blue Shield of Illinois (BCBSIL) will review and respond to any Independent Physician Association (IPA) written appeal of a failed UM Adherence Audit.

Purpose:
- To establish guidelines for IPA appeal of failed UM adherence audit results
- To allow feedback from IPA related to a failed UM adherence audit
- To bring the IPA back into compliance with audit standards

Procedure:
1. The IPA has 60 days from the date of the UM Adherence Audit result notification letter to notify HMO, in writing, of the desire to appeal the failed audit results. The HMO will send a results determination letter of the appeal to the IPA within 30 calendar days.

2. In the IPA request for appeal, documentation must be submitted if a failed score is being challenged. Additional information that was not available at the time of the audit will not be accepted as part of the appeal.

3. The case review portion of the audit cannot be appealed. The case review should be discussed before the auditor leaves the audit. Case review score at the end of the audit will be considered final.

4. For the first level UM appeal, the HMO Nurse Liaison will review the documentation and/or audit scoring with the HMO UM Manager/QI/ UM Project Consultant and Network Director. Attachments required to pass the audit must be included at the time of audit with the committee meeting information.

5. Decision of this first level review will be communicated to the IPA within 15 business days of the appeal request.

6. The second level appeal is to the HMO Workgroup and BCBSIL Medical Director for final determination.

7. Written findings of the second level appeal will be sent to the IPA within 15 calendar days of the final appeal review by the HMO.

8. No appeals will be heard for passing UM audit scores or case file review.
Policy Name: Ancillary and Hospital Institution Care Transition and Exceptions

Policy Number: Administrative-11
Effective Date: 11/1/97
Revised Date: Review Date: 1/1/10

Policy:
HMOs of Blue Cross and Blue Shield of Illinois contract with Ancillary and Hospital Institutions that are accredited with The Joint Commission or another approved accreditation body and meet specific criteria as outlined in the Ancillary and Hospital Credentialing/Recredentialing Requirements policy. The ancillary categories affected by this policy include hospitals, skilled nursing facilities (SNF), home health care agencies (HHC), ambulatory surgery centers (ASC), and inpatient, residential and ambulatory, behavioral health facilities (BHF) and freestanding surgical centers.

Purpose/Objectives:
- To facilitate the transition of medical care from a non-contracting institution to a contracting institution.
- To ensure timely involvement by the Primary Care Physician (PCP) in the transition of medical care.
- To minimize disruptions of medical care and prevent adverse clinical outcomes.
- To avoid additional unit charge backs against the Utilization Management (UM) Fund.

Procedure:
Transition of Medical Care:

1. When an Independent Physician Association (IPA)/PCP is notified of a member's medically necessary admission to a non-group approved and/or non-accredited facility, the IPA/PCP must contact the attending physician within one business day from the date of notification of the admission to the facility.

2. In the event the attending physician and the PCP determine the member to be medically stable for transfer to a contracted and/or accredited facility, the IPA/PCP initiates the transfer to a contracted facility. Note: If the member refuses to be transferred, refer to the Termination of Benefits section in the HMO Provider Manual.

3. IPAs will receive the higher charge back penalty against the UM Fund and any other contractual penalties applicable if the member has not been transitioned to a contracted facility and/or an exception has not been approved.
Ancillary and Hospital Institution Care Transition and Exceptions
Page 2 of 2

4. IPAs experiencing difficulty in locating feasible institutions should contact their HMO Provider Network Consultant, Nurse Liaison, HMO Medical Director or Associate Medical Director for assistance.

IPA/PCP Request for Exceptions:

1. IPA/PCPs can request exceptions from the HMO Provider Network Consultant, Nurse Liaison, HMO Medical Director or Associate Medical Director to extend the transition timeframe or to utilize non-contracting ancillary or hospital institutions.

2. Exceptions must be submitted in written format, by the IPA/PCP, detailing at a minimum the following:
   - Reason for extension or use of a non-contracting institution
   - Timeframe requested
   - Member’s Diagnosis
   - Member Information (Name, Group/ID number, etc.)
   - Applicable Institution

3. Exception requests are sent to Provider Contracting to negotiate a one time contractual rate. If the exception request is approved, an UM exception form is completed by HMO and a copy is given to the IPA. The IPA UM Fund will not be penalized with higher UM charge back units nor will any other contractual penalty be applied.

4. Provider Contracting will request all non-accredited Ancillary and Hospital institutions to inform HMO Members to contact their IPA/PCP and/or the HMOs with concerns or questions.

5. In the event the exception is not granted, the higher UM charge back will be imposed on the IPA’s UM Fund and any other contractual penalties applicable.
Policy:

The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) are responsible for ensuring that all new physicians joining an existing IPAs meet the credentialing, utilization management, quality site visit, and other contractual requirements identified in the Medical Service Agreement.

Purpose/Objectives:

To outline the requirements that must be met by new physicians joining an existing IPA prior to contracting with BCBSIL HMO.

To outline the process and ensure that contracting physicians meet all credentialing requirements prior to seeing HMO patients.

To identify the requirements for reapplication to an HMO network, if the initial requirements are not met.

Procedure For New Physicians To Existing IPAs:

The Credentialing unit identifies and evaluates new physicians applying for participation to existing IPAs in the HMO networks. The new physician must meet the following site visit thresholds:

- Accessibility – 90%,
- Facility and Emergency – 90%,
- Quality of patient care – 90%,
- Quality of record entry – 90% and
- Preventive – 90%.

If a physician does not have passing scores in every site visit category, the physician is not appointed to the HMO networks. The physician may reapply to the HMO network in six months.

If scores meet criteria and all credentialing is completed, Network Operations will present a list of physicians to the Provider Selection Committee. A report is produced monthly of appointed/reappointed physicians.
Policy Name: Credentialing for Prospective HMO IPAs
Policy Number: Administrative-45
Effective Date: 11/1/99
Revised Date: 1/1/10

Approval Signature:

<table>
<thead>
<tr>
<th>Senior Medical Director</th>
<th>Vice President–Network Management</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>HMO Illinois, BlueAdvantage</td>
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<td></td>
<td>HMO</td>
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<td>Approved QI:</td>
<td>1/6/10</td>
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<td>Approved P&amp;P:</td>
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Policy:

The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) are responsible for ensuring all prospective Independent Physician Associations (IPAs) meet the credentialing, utilization management and other contractual requirements identified prior to participation in the HMO Illinois or BlueAdvantage HMO Network.

Purpose/Objectives:

- To outline the requirements that must be met by a prospective IPA prior to contracting with BCBSIL HMO.
- To outline the process and ensure that contracting physicians meet all credentialing requirements prior to seeing HMO members.
- To identify the requirements for reapplication of the physician and/or IPA to an HMO network if the initial requirements are not met.

Procedure:

Credentialing

The HMO Network will submit to the Credentialing Department a roster of participating physicians and complete credentials for each physician. This will be done prior to finalizing the Medical Service Agreement and acceptance of the Utilization Management (UM) plan, if the HMO Network determines the group is likely to meet all contracting requirements.

The prospective IPA must meet the initial physician panel requirement consisting of at least two Primary Care Physicians (PCPs) in each of these specialties:

1) a) Family Practice, General Practice, or Internal Medicine;
   b) Pediatrics;
   c) Obstetrics-Gynecology (OB/GYN).

(Note: A Family Practitioner who provides obstetrical and gynecological care may count as one of the two PCPs with a specialty in OB/GYN and/or a Family Practitioner who provides services for children, starting at birth, may count as one of the two Pediatricians. OB/GYN PCPs must provide direct access for Women’s Principal Health Care Provider Members.)
Credentialing for Prospective HMO IPAs
Page 2 of 2

2) at least one physician in each of these specialties:

   a) Allergy/Immunology;
   b) Cardiology;
   c) Dermatology;
   d) General Surgery;
   e) Gastroenterology
   f) Neurology;
   g) Oncology (Medical)
   h) Ophthalmology;
   i) Orthopedics;
   j) Otolaryngology;
   k) Psychiatry;
   l) Urology;
   m) Hospital Based Physicians: Anesthesiology, Radiology, Pathology, Emergency Medicine and Neonatology (if applicable)

The Credentialing Department reviews all of the credentialing applications for completeness. Any physicians with missing credentials are returned to IPA. Credentialing will produce a physician roster and verify with the HMO Network that the list is complete.

Once all credentialing requirements are completed, Network Operations will present a list of physicians to the Provider Selection Committee.

A report is produced monthly of appointed / reappointed physicians. The report for the prospective IPAs will list physicians that have been appointed.

Utilization Management

HMO Network will forward to the UM Nurse Liaison the prospective IPA’s UM plan.

The UM Nurse Liaison will review the plan for compliance to the current year’s standards for BCBSIL HMO. If the IPA passes, the UM Nurse Liaison will send a letter to the IPA. If the IPA does not meet UM standards, the UM Nurse Liaison will notify the IPA of deficiencies and require a response within 30 days.

If a response is received within 30 days, the UM Nurse Liaison will re-evaluate the plan and repeat the steps above. If a response is not received, the IPA, HMO Network and the Credentialing Department will be notified of closing of the file within 30 days. This would be notification to cease working on this group.

If UM, Credentialing, and Contracting requirements are met, HMO Network will present the IPA to Network Development for signature of the Medical Service Agreement. HMO Network will notify the IPA of the disposition of contracting and notify all impacted departments of the effective date for the IPA.
Policy Statement:

The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) will use this policy along with an Independent Physician Association’s (IPAs) documentation to determine whether it is appropriate to request a member’s transfer from that IPA. A request for a member’s transfer may not be based on the type, amount, or cost of service that a patient legitimately requires.

Guidelines:

The IPA has the right to request that HMO Illinois/BlueAdvantage HMO remove a member when that member disrupts their normal business practice. An IPA’s request for a member transfer is viewed by the HMOs of BCBSIL as a significant and serious event. The consequences of a member’s transfer will mean the disruption of that member’s care and it is important that a documented process is carefully followed. The final decision is made by the HMOs of BCBSIL to involuntarily transfer a member out of an IPA.

Procedure:

1. The IPA has the right to initiate the process of requesting a member transfer. Prior to an IPA’s request to transfer a member out of the IPA, a minimum of one warning letter must be sent by certified mail to the member if one of the following occurs:

   a. Living outside of the HMO Service Area.

      1. A member resides at such a distance from the Primary Care Physician (PCP) that it does not allow the Physician to coordinate care appropriately, or

      2. A member resides at such a distance from the PCP that the member persistently demonstrates non-compliance.

   b. Persistent non-compliance of prescribed medical regimens.

      1. A patient has demonstrated clear non-compliance with a prescribed medical regimen and the consequences of that non-compliance is the high likelihood of significant medical complications.

      2. It is presumed that in lieu of the disputed medical care, there are no other alternative medical treatments that are acceptable to the patient.
IPA Request for Member Transfer
Page 2 of 3

3. Written documentation to the patient must exist describing the need for the treatment, the medical consequences associated with not following the treatment, and the potential consequences of being transferred out of the IPA if the regimen is not followed. Concurrence by the IPA’s Quality Review Committee for the need of the care would strengthen the documentation.

4. Instances of refusal to make certain prescribed lifestyle changes, such as stop smoking, or loss of weight, generally will not be considered a refusal of a prescribed medical regimen.

c. Missing scheduled appointments.

1. A patient misses appointments such that the lack of medical care becomes a serious health issue, or

2. A patient misses three appointments without calling at least 24 hours prior to the appointment, in a period not greater than 18 months. It is expected that the member be warned in writing of the IPA’s policy and the consequences of continued missed appointments. Also the letter to the member should include instructions how the member can contact the IPA administration for assistance in resolving the issue.

d. Behavior that is significantly disruptive to the delivery system or which causes an irreparable breach in the patient/physician relationship.

1. A member acts in a way that causes significant disruption to the delivery system operation.

2. It is expected that an administrative staff member speak with the member so that a complete understanding of the incident can be achieved.

3. If after this conversation the IPA believes the member acted unreasonably and inappropriately, a letter should be sent to the member reviewing the incident and issuing a warning that repeated occurrence could result in being asked to leave the IPA.

e. Verbal or written threat of legal action against the IPA.

If a member threatens legal action against the IPA Physician, it is expected that the IPA administration contact the member to investigate the member’s complaint. Because a threat of legal action is a clear indication by a member of a complaint against the group, the complaint and results of the investigation must be documented in the IPA Complaint log. The findings of the complaint could initiate a warning letter to the member.

f. Non-payment of required co-payments.

A member refuses to pay the required co-payments for services or any previously unpaid bills after being warned in writing that the consequences of refusal will be removal from the IPA. The warning letter must direct the member to contact the IPA by a specific date to make payment arrangements. If non-compliance continues, the IPA will initiate the member transfer request process.
IPA Request for Member Transfer

2. The warning letter must include the following information:
   a. The nature of the infraction.
   b. The required member action with related time frames.
   c. Instructions on how the member can contact the IPA administration for assistance in resolving the issue.

   The warning letter for this incident will be valid for a 12 month period. If this incident occurs again, outside of the 12 month period, a new warning letter will be required.

3. After the warning letter requirements have been met and the IPA requests to transfer the member out of the IPA, the request must be sent in writing to the BCBSIL Provider Network Consultant.

   The letter must include all relevant documentation sent to or received from the member including:
   a. Written documentation of the events that led up to the request by the IPA.
   b. Evidence of the IPA’s good faith attempt to resolve the problem.
   c. Evidence that the IPA followed their own internal due process for the member complaint resolution.

4. The Provider Network Consultant will review the IPA request for member transfer letter and approve the request if policy protocol has been met.

5. HMO BCBSIL will send a member transfer request letter to the member explaining that a problem has occurred between the IPA and the member. The member will be given a period of 30 to 45 calendar days from the date of receipt of the member transfer request letter to select a new IPA. The current IPA will be responsible for providing or coordinating emergency and urgent care up to the effective date with the new IPA.

6. The following situations will warrant a member transfer request where an initial warning letter is not required:
   a. Police intervention at the IPA, behavior resulting in the member’s arrest at the IPA, or a member’s involuntary removal from IPA premises by the IPA staff and/or police.
   b. A member intentionally causes bodily harm to IPA staff.
   c. When an actual law suit or claim has been filed against the IPA Physician.
   d. Fraud (altered medical records, forged prescriptions, identity theft).
   e. A member displays inappropriate physical contact to IPA staff.

NOTE:

The only situation that does not require the 30 to 45 day grace period to place a member in a new IPA is when a member has been previously removed from the IPA. After the request for removal has been communicated by the IPA to HMO, HMO will place the member in a pend status (597) until a new IPA is chosen. All medical care claims incurred during this time span will be reviewed for payment on an individual basis by BCBSIL.
Policy Name: Retroactive IPA Member Changes
Policy Number: Administrative - 32
Effective Date: 7/21/99
Revision Date: 5/1/10

Policy:
The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) will provide established guidelines for appropriate HMO staff to facilitate retroactive Independent Physician Association (IPA) change requests from existing HMO members.

Purpose:
- To ensure proper procedures are followed when members contact the HMO to request their IPA selection be made retroactive.
- To ensure proper procedures are followed when notifying the IPA of the retroactive IPA change.
- To provide guidelines and criteria for appropriate HMO staff to determine when a retroactive IPA change can be facilitated.
- To provide guidelines and criteria for appropriate HMO staff to determine how to handle corrections for retroactive medical group changes.

Definition:
An IPA change is considered retroactive if the HMO receives the request after the first day of the month, to be effective the first day of that month or any previous month.

Guidelines:
- Retroactive IPA change requests can only be made by HMO member and/or an authorized personal representative of the HMO member. The request must be made in writing or via telephone. The IPA change requests received by other HMO Departments must be routed to the HMO Full Service Units (FSU) via the Inquiry Reporting and Information System or IMAGE for processing.
- The HMO FSU and Health Care Management (HCM) are the only areas that can approve a retroactive IPA change and determine the validity of the request.
- The only situations that would qualify for a retroactive IPA request would be the following:
  - Member is assigned to a 597, 598 or 599 IPA.
  - Member has moved outside of the current IPA service area.
Retroactive MG/IPA Member Changes
Page 2 of 5

- Member was assigned to the current IPA due to an error by the HMO Membership Department, Marketing, the member or the employer group.
- Member is a newborn.

- Making a retroactive IPA change does not guarantee payment of any unpaid or non-group approved claims the member may have incurred without proper authorization or referral from their IPA, Primary Care Provider or Woman's Principal Health Care Provider.

- Emergency room services would be considered for payment under normal HMO guidelines.

- Retroactive IPA changes for newborns should be handled based on the Newborn Policy and Procedure determined by the child’s date of birth.

Procedure:

Scenario I - 597, 598 or 599

A. If the member is assigned to a 597, 598 or 599 IPA, the HMO FSU or HCM staff will be required to verify the following information.

1) Check the member’s file for any correspondence and telephonic history related to IPA selection.

2) Check for any claims processed for the member during the time period of the retroactive IPA request. If there are claims on file, the claims should be processed and sent to the selected IPA.

B. Staff will be required to ask the member or the authorized representative, the following questions.

1) Is the member currently hospitalized?
   - If no, continue to next question.
   - If yes, staff must notify the selected IPA of the admission to coordinate care to discharge and the IPA would be responsible for any claims incurred effective the date of notification. Continue to the next question.

2) Is the member in their 3rd trimester of pregnancy or will be in the 3rd trimester when the IPA request is effective?
   - If no, continue to next question.
   - If yes, staff must notify the selected IPA to coordinate the member’s care and the IPA would be responsible for any claims incurred effective the date of notification. Continue to the next question.

3) Has the member received services at the selected IPA or at any other IPA during the time period of the requested retroactive IPA change?
   - If no, the retroactive IPA change can be completed.
   - If yes, the retroactive IPA change can be completed but staff should determine if the services were coordinated by the selected IPA.
Retroactive MG/IPA Member Changes  
Page 3 of 5

- If the selected IPA coordinated the care, they would be responsible for all claims incurred.
- If the services were not coordinated by the selected IPA, the claims incurred would be subject to HMO review.

Scenario II – Moved Outside of IPA

A. If the member moved outside of the current IPA service area, staff will be required to verify the following information.

Verify the current IPA selection and the address on file for the member. Staff must determine if the member has moved beyond the service area of the current IPA. If the member has moved out of the service area, the retroactive IPA change can be made with a retroactive date.

1) Check for any previous notes related to an IPA selection or address change.

2) Check for any claims processed for the member during the time period of the retroactive IPA request. If there are claims on file, staff will determine if the member was self referred or if the care was coordinated by an HMO IPA physician. Continue to the next series of questions.

Note: If the member has not moved out of the service area, the retroactive change can not be made at this time. The member will be offered the option of making the change effective the 1st day of the next month.

B. Staff will be required to ask the member or the authorized representative the following questions.

1) Is the member currently hospitalized or was the member hospitalized during the time period requested for the retroactive IPA change?
   - If no, continue to next question.
   - If yes, staff must determine who is coordinating the member’s care.
     - If the newly selected IPA is coordinating the care, the retroactive IPA change can be made and the IPA would be responsible for all claims incurred.
     - If the member was self referred or a non-HMO IPA physician is coordinating the care, the retroactive IPA change can be made but the claims would be subject to HMO review.
     - The new IPA should be notified of the admission to coordinate care to the time of discharge and the IPA would be responsible for any claims incurred effective the date of notification. Continue to the next question.

2) Is the member in their 3rd trimester of pregnancy or will be in the 3rd trimester when the IPA request is effective?
   - If no, continue to next question.
   - If yes, staff should refer to the 3rd Trimester Pregnancy IPA Transfer Policy and Procedure.

3) Has the member received services at the selected IPA?
   - If no, continue to the next question.
Retroactive MG/IPA Member Changes
Page 4 of 5

- If yes, if the newly selected IPA is coordinating the care, the retroactive IPA change can be made and the IPA would be responsible for all claims incurred. Continue to the next question.

4) Has the member received services at any other IPA during the time period of the requested retroactive IPA change?
   - If no, the retroactive IPA change can be completed.
   - If yes, the retroactive IPA should be completed only if the member is in need of additional services for the current time period with the newly selected IPA. The prior claims incurred with any other IPA would then be subject to HMO review.
     - If the member is not in need of additional services for the current time period with the newly selected IPA, the retroactive change can not be made at this time. The member will be offered the option of making the change effective the 1st day of the next month.

Scenario III – Incorrect IPA Assignment

A. If the member was assigned to the current IPA due to an error by the HMO Membership Department, Marketing, the member or the employer group, staff will be required to verify the following information.

1) Verify the current IPA selection.

2) Check for an application on file with an IPA selection to verify the error.

3) Check for any previous notes related to an IPA selection to verify the error.

4) Check for any claims processed for the member during the time period of the retroactive IPA request. If there are claims on file, staff will determine if the member was self referred or if the care was coordinated by an HMO IPA physician. Continue to the next series of questions.

B. Staff will be required to ask the member or the authorized representative, the following questions.

1) Is the member currently hospitalized or was the member hospitalized during the time period requested for the retroactive IPA change?
   - If no, continue to next question.
   - If yes, staff must determine who is coordinating the member’s care.
     - If the newly selected IPA is coordinating the care, the retroactive IPA change can be made and the IPA would be responsible for all claims incurred.
     - If the member was self referred or a non-HMO IPA physician is coordinating the care, the retroactive IPA change can be made but the claims would be subject to HMO review.
     - The new IPA should be notified of the admission to coordinate care to the time of discharge and the IPA would be responsible for any claims incurred effective the date of notification. Continue to the next question.
2) Is the member in their 3rd trimester of pregnancy or will be in the 3rd trimester when the IPA request is effective?
   - If no, continue to next question.
   - If yes, HMO FSU or HCM staff must determine who is coordinating the member’s care.
     - If the newly selected IPA is coordinating the member’s care, the retroactive IPA change can be made and the IPA would be responsible for all claims incurred.
     - If the newly selected IPA is not coordinating the member’s care, staff should contact the HMO Provider Network Consultant by using the appropriate internal procedure. Continue to the next question.

3) Has the member received services at the selected IPA?
   - If no, continue to the next question.
   - If yes, if the newly selected IPA is coordinating the care, the retroactive IPA change can be made and the IPA would be responsible for all claims incurred. Continue to the next question.

4) Has the member received services at any other IPA during the time period of the requested retroactive IPA change?
   - If no, the retroactive IPA change can be completed.
   - If yes, the retroactive IPA can be completed. The prior claims incurred with any other IPA would then be subject to HMO review.

Finalization

- If a retroactive request is not approved, the HMO FSU or HCM will advise member of the appeal process for any claims incurred. The member will be offered the option of making the change effective the 1st day of the next month.

- The IPA will be notified of the approved retroactive IPA change via the online and/or paper eligibility report with the effective date of the change. IPA will receive capitation for the retroactive months involved, and services provided or referred by the IPA will be the IPA responsibility to pay.

- The HMO FSU and HCM staff must document all pertinent information into the Inquiry Reporting and Information System. See Departmental Guidelines.
Policy:
The HMOs of Blue Cross and Blue Shield of Illinois will specify how members may access standing referrals under appropriate clinical circumstances.

Purpose/Objectives:
- To specify criteria to be met so that a member, having a disease or condition requiring an ongoing course of treatment from a specialist or other health care provider, may obtain, upon request, a standing referral from his/her Primary Care Physician (PCP).
- To specify a procedure to initiate and renew a standing referral.

Definitions:
- **Standing Referral**: means a written referral from the PCP for an ongoing course of treatment pursuant to a treatment plan specifying needed services and time frames developed by a specialist in consultation with the PCP and in accordance with procedures developed by the health care plan.

- **Ongoing Course of Treatment**: means the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a physician.

Guidelines:
- This is a single referral, provided at the discretion of the PCP, specifying duration, type and frequency of specialist services to complete an ongoing course of treatment.

- The IPA must provide the HMO with a written policy and procedure addressing process related to standing referrals.

Procedure:
1. The PCP writes a single referral, upon request, to address the needs of a member who has a disease or condition that requires an ongoing course of treatment from a specialist (or other health care provider).

2. The standing referral follows the IPA normal process for approval unless the process is detailed in a separate policy and procedure. The standing referral remains valid for the specified time period or for one year, whichever comes first. The PCP may renew a standing referral if the member continues to need specialist services for the same ongoing course of treatment.
3. In the event of termination of the member’s benefits or the specialist’s contract, the standing referral is no longer valid, except if all conditions in the Transition of Care Policy are met. The medical group must notify the member in a timely manner if the specialist no longer has a referral arrangement with the medical group. The medical group and the PCP must redirect the member to an appropriate specialist who would provide services related to the member’s ongoing course of treatment as specified in the original standing referral.

4. If the member changes medical groups, the standing referral is no longer valid. The member must obtain another standing referral from the PCP in his/her new medical group. If the member changes PCP’s within the same medical group and this change does not affect the medical group’s contractual arrangement with the specialist, the original standing referral remains valid.
Policy:
The HMOs of Blue Cross and Blue Shield of Illinois will provide established guidelines for appropriate HMO staff to facilitate requests for female members to change their Independent Physician Association (IPA) affiliation while in their 3rd trimester of pregnancy.

Purpose/Objectives:
- To establish criteria that allows a female member to transfer her Woman’s Principal Health Care Provider (WPHCP) or Primary Care Physician (PCP) IPA affiliation while in the 3rd trimester of pregnancy.
- To ensure proper procedures are followed when members contact the HMO to request an IPA change while in their 3rd trimester of pregnancy.

Guidelines:
3rd trimester IPA changes will be allowed under the following circumstances:
- The member’s IPA closes (Reference - Closed IPA Policy)
- The member’s OB/GYN or WPHCP leaves the IPA and transfers affiliation to another BCBSI HMO IPA.
- The member moves to another geographic area, beyond the service area of their existing IPA. The service area is defined as within 30 miles from the member’s IPA medical office.
- The HMO has substantiated a Quality of Care complaint based on the nature of the complaint and the member’s dissatisfaction with their current WPHCP or PCP. (Refer to Clinical Definition of Quality of Care inquiries/complaints in the Quality of Care Complaint Procedure).

Procedures:
1. A member calls the HMO Full Service Unit (FSU) to request a WPHCP or PCP IPA change.
2. The following questions should be asked:
   a. Are you, or the member for whom the change is being requested, in their 3rd trimester of pregnancy or will be when the IPA change becomes effective?
   b. Are you, or the member for whom the change is being requested, currently hospitalized?
If the answer is ‘Yes’ to question 2a:

1. The member should provide a reason for the IPA change request. If the request does not meet the guidelines as stated in this policy, then the IPA change request should be denied until after the member’s expected delivery date.

If the member asks for an additional review, the member will be referred to the HMO Customer Assistant Unit (CAU) department. The CAU will review the request and may contact the requested IPA to ask if they can accommodate the member’s request. The CAU staff will also involve the Provider Network Consultant as needed. The member will be notified by the HMO CAU staff of the outcome. If the WPHCP or PCP IPA change is approved, the HMO CAU staff will work with the HMO FSU staff to process the IPA change, and to notify the IPA of the new member.

2. If the member’s request meets the guidelines as stated in this policy, the HMO FSU staff will process the WPHCP or PCP IPA change.

3. The HMO FSU staff will contact the IPA to inform them that a member, in her 3rd trimester of pregnancy, has been assigned to their IPA.

If the answer is ‘Yes’ to question 2b:

HMO staff will inform the member that an IPA change cannot be made at this time.
Policy Name: Contract Management Firms: Confidentiality Agreement
Policy Number: Administrative-14
Effective Date: 12/1/97
Revised Date: Review Date: 11/1/09

Approval Signature:
Senior Medical Director
Vice President—Network Management

Policy:

A Contract Management Firm (CMF) is a subcontractor retained by the Independent Physician Association (IPA) to perform certain management and administrative functions. A Confidentiality Agreement will be executed between the IPA, the CMF, and Health Care Services Corporation (HCSC).

Purpose/Objectives:

To ensure that all information and data considered of a confidential nature (as defined in the Confidentiality Agreement) is acknowledged and preserved by the IPA and the CMF.

Procedure:

1. A signed and dated Confidentiality Agreement will be executed by all parties (IPA, CMF, HCSC) and will remain in effect for as long as the Medical Service Agreement (MSA) remains in effect.

2. Upon execution of a Confidentiality Agreement, by the HMO, the IPA, and the CMF, the IPA may assign certain of its administrative, and management duties and responsibilities to a CMF.

3. Under the MSA, the IPA will be fully responsible and liable for performance of any duties and functions performed by IPA but delegated to a CMF.

An assessment of how well the CMF performs the delegated function(s) will be noted in the IPA quarterly oversight report to the HMOs of Blue Cross and Blue Shield of Illinois.
Policy Name: Individual Benefits Management Program (IBMP)

Policy Number: Administrative-19

Effective Date: 12/19/97

Revised Date: 1/1/10

Policy:
The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) will assure that members have access to extracontractual alternative benefits, (i.e. Skilled Private Duty Nursing) based upon medical appropriateness and cost effectiveness. Such benefits are termed Individual Benefits Management Program (IBMP).

Purpose/Objectives:

- To promote high quality health care in a manner, which enhances the patient’s quality of life and utilizes the most cost effective resources
- To increase patient satisfaction and promote recovery by giving the patient the opportunity to participate with the HMO, the Primary Care Physician (PCP), or Women's Principal Health Care Provider (WPHCP) and the Independent Practice Association (IPA) in designing a treatment and benefit plan which facilitates transfer to an alternative setting. This transfer period shall not exceed six months in duration.
- To promote education of the patient/caregiver in the treatment plan

Guidelines:
The HMOs of BCBSIL will review requests made by IPA PCP for skilled private duty nursing under the IBMP. When a written IBMP request is made to the HMO by the PCP or WPHCP, a BCBSIL representative will meet, either in person or telephonically, with the hospital discharge planner, subscriber or authorized representative, medical group’s case manager and if possible, the PCP or WPHCP to outline the following criteria to be used to evaluate and possibly approve the request:

- Skilled Private duty nursing in the home setting will be approved if it is more cost effective than anticipated in-benefits services.
- Social needs (i.e. Parents’ work schedule, vacations, or the care of other family members within the home) will not be the sole reason for granting IBMP.
- The PCP or WPHCP must verify that the proposed service is medically necessary.
- The patient caregiver is able to comprehend and provide for the patient’s care and is willing to assume responsibility for the care.
- The PCP or WPHCP must provide written patient updates to the HMO every two months, to assist the HMO in evaluating coverage for continued benefits for the services outlined in the Authorization for Alternative Benefits.
The IPA shall be responsible for directing and managing all the care under the IBMP and will coordinate and monitor all care rendered to the patient.

- The IPA shall be responsible for Utilization Management.
- All parties will sign an Acknowledgement Form to confirm participation and understanding of the terms of the Authorization for Alternative Benefits if one should be approved.
- The IPA must ensure that there is at least one caregiver available who is actively involved, is willing to be educated in order to provide for the patient’s care, or make other provisions for care.

**Procedure:**

1. The PCP or WPHCP must submit a written request for an IBMP to the HMO Nurse Liaison (NL) which includes the IPA Medical Director or designee’s signature and a completed Treatment Plan and Social Assessment Summary (Attachment 1). This worksheet includes, but is not limited to:
   a. A description of the patient’s condition
   b. Treatment options available
   c. A completed social service evaluation description of services/treatment requested
   d. The PCPs recommendation for the level of professional care (e.g. RN, LPN, etc.) and number of hours per day
   e. A statement of medical appropriateness of requested services or treatment
   f. Anticipated duration of services/treatment
   g. Identification of a caregiver who is able to comprehend and provide for the patient’s care and is willing to assume responsibility for the care
   h. Any other relevant documentation

2. The IPA will recommend a Home Health Agency that is contracted with BCBSIL to provide Private Duty Nursing. The provider must have a private duty nursing provider number with BCBSIL.

3. The Authorization for Alternative Benefits includes:
   a. the maximum length of time of the IBMP (not to exceed six months)
   b. the IBMP will be re-evaluated every two months prior to the expiration of the authorization for Alternative Benefits in accordance with the IBMP Policy
   c. the Primary Care Physician (PCP) will recommend the level of professional care (e.g. RN, LPN, etc.) and number of hours per day
   d. the caregiver (family) is actively involved, is willing to be educated in order to provide the patient’s care or make other provisions for care
   e. the IPA is responsible for Utilization Management
   f. Acknowledgement Form signed by all required parties

4. Prior to implementation of an IBMP, the Authorization for Alternative Benefits *(Attachment 2)* including the Acknowledgement Form (Attachment 3) must be completed and signed by all required parties:
   - PCP or WPHCP
   - Subscriber or subscriber’s authorized representative
   - BCBSIL Medical Director

5. The NL will distribute copies of the Authorization to the following:
   a. All signatories
   b. IPA
   c. Network Consultant
Individual Benefits Management Program (IBMP)

6. The NL will complete and distribute copies of the **VIP Claims Memo for Negotiations** (Attachment 4) to the following:
   a. HMO Full Service Unit
   b. The Home Care Provider (the provider must have a private duty nursing provider number with BCBSIL. Refer to the list provided by contracting).

7. The Home Health Agency will send all claims to the HMO FSU for review and consideration for payment.

8. The IBMP will be re-evaluated every two months prior to expiration of the Authorization for Alternative Benefits in accordance with this IBMP Policy.

9. Should the IBMP not be re-approved, the NL and IPA case manager are available to assist the subscriber in the transition of care to the patient/caregiver.
DATE

Dear Provider:

Attached is a Treatment Plan and Social Assessment Summary worksheet, which must be completed in order for your Individual Benefits Management Program (IBMP) request to be reviewed. This summary should only be completed following the Medical Director, PCP/Family conference in which the patient/family is informed of the purpose of IBMP and alternative of care. You may want to include your IPA Case Manager and a Clinical Social Worker in the patient/family conference to develop a long range treatment plan to prepare for the level of care when the IBMP Authorization ends.

Be sure to include the name and telephone number of the person(s) who completed this form.

Upon completion, please fax this worksheet to the HMO Nurse Liaison, (name R.N.,) (312) 653- . You will be notified of the determination.

A copy of the IBMP policy is attached for your review.

Reviewed 1/1/10
In order to evaluate the request for Private Duty Nursing in the home setting, the Primary Care Physician (PCP) must complete the following pages in their entirety.

Subscriber: _______________     Patient: _______________

Group and ID#: _______________________________________

PAST MEDICAL HISTORY:
_____________________________________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________________________________

DIAGNOSIS AND CURRENT MEDICAL CONDITION:
_____________________________________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________________________________

LIST ALL PRIMARY CAREGivers (RELATION, AVAILABILITY & IF CPR CERTIFIED):
__________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________

IF ANY OTHER CHILDREN IN THE HOME, LIST THE CAREGIVER OF SIBLING(S) DURING PRIVATE DUTY NURSING INVOLVEMENT OF PATIENT:
__________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________

SPECIFIC TREATMENT PLAN OF PATIENT:
__________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________

SPECIFIC SKILLED NURSING NEEDS AND FREQUENCY:
__________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________
BACK-UP TREATMENT PLAN OF PATIENT (INCLUDE ALTERNATIVE CARE SETTINGS AND METHODS)

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

*NAME AND PHONE NUMBER OF HOME CARE AGENCY REQUESTED:

___________________________________________________________________________________________

REQUESTED NUMBER OF PRIVATE DUTY NURSING HOURS:

___________________________________________________________________________________________

SPECIFIC TREATMENT RECOMMENDATION:

___________________________________________________________________________________________
___________________________________________________________________________________________

*Home Care Agency must have a Private Duty Nursing provider number with BCBSIL.

INFORMATION COMPLETED BY:

___________________________________________________________________________________________

TELEPHONE #:

___________________________________________________________________________________________

PCP SIGNATURE & DATE:

___________________________________________________________________________________________

MEDICAL DIRECTOR SIGNATURE & DATE:

___________________________________________________________________________________________

DATE SUBMITTED TO HMO MEDICAL DIRECTOR & DIRECTOR: ___________
AUTHORIZATION
FOR
ALTERNATIVE BENEFITS

HMO: HMOs of Blue Cross Blue Shield of Illinois (HMO Illinois and BlueAdvantage HMO)

Subscriber Name: ----

Group Number/Subscriber Number: ----

Patient Name: ----

Subscriber’s Relation to Patient: ----

IPA: ----

Patient’s Primary Care Physician: ----

Employer Group: ----

Under the terms of the Blue Cross Blue Shield of Illinois HMO (HMO) Medical Service Agreement (Agreement), <<IPA>> has authorized HMO to provide Alternative Benefit Coverage (Alternative Benefit). The Primary Care Physician (PCP) and the subscriber have requested this Alternative Benefit for the above named patient.

This Authorization for Alternative Benefits (Authorization) may be for a maximum period of six months and shall be evaluated every two months with respect to appropriateness. During this time the caregivers shall receive comprehensive care instruction from the Home Health Care Agency and/or other provider regarding the care of the patient enabling the caregiver to assume responsibility for the patient at the termination of this Authorization.

The Alternative Benefits for <<insert benefit here>>, agreed upon for purposes of this Authorization, are as follows:

<<insert benefit to be received and location of care>>
An evaluation to authorize continued Alternative Benefits shall be done at least every two (2) months. To complete this evaluation, the HMO requires the following documents be submitted:

- Primary Care Physician written patient evaluation
- Treating physician’s progress notes (if other than the Primary Care Physician)
- Home Health Care Notes (including caregivers involvement with care and caregivers progress in assuming the responsibility for care)

<< IPA >> agrees to coordinate management of these alternative benefits and perform utilization review and quality assurance as described in the Agreement between HMO and <<IPA>>.

The patient or custodian on the patient’s behalf agrees that HMO shall be provided with any and all information it requires including but not limited to medical records and documentation according to the Authorization.

The following shall result in termination of this Authorization:

- Failure to provide information or documentation
- Disruption of home health care services

This Authorization shall become effective when fully executed and may continue for the period (not to exceed six months). No representation or guarantee is made with respect to continuation of the Alternative Benefits beyond the termination date.

All benefits paid pursuant to this Authorization are subject to the Coordination of Benefits provision in Your Certificate of Health Care Benefits.

Your signature below indicates your agreement with this Authorization

___________________________   ________________________
Subscriber, <<subscriber name>> for
Himself, and on Behalf of Patient
as Next of Kin

Date

______________________________  ____________________________
Dr. <<PCP name>>, Patient’s Primary
Care Physician, <<IPA>>

Date

______________________________  ____________________________
Dr. Kim Reed, Medical Director
BCBSI Representative

Date

Reviewed 1/1/10
Acknowledgement Form

HMOI and BlueAdvantage HMO
Understanding and Compliance of
Individual Benefits Management Program

IPA Name: _______________________________ IPA#: __________

Patient Name: ____________________________________________

Patient DOB: ______________________

Subscriber Name: __________________________________________

Subscriber ID: __________________________ Group #: __________

Diagnosis: ________________________________________________

I have been informed and understand the terms and conditions of the Individual Benefits Management Program (IBMP) Policy. I understand that by signing this acknowledgement form, I understand and agree to comply with the IBMP policy as follows:

- The maximum length of time of the IBMP is not to exceed 6 months
- The IBMP will be re-evaluated every 2 months prior to the expiration of the Authorization for Alternative Benefits in accordance with the IBMP Policy
- The Primary Care Physician (PCP) will recommend the level of professional care (e.g. RN, LPN, etc.) and number of hours per day
- The caregiver (family) is actively involved, is willing to be educated in order to provide for the patient’s care, or make other provisions for care
- The Independent Physician Association (IPA) is responsible for Utilization Management.

Subscriber _______________________________ Date

Primary Care Physician _______________________________ Date

Medical Director, BCBSIL _______________________________ Date

Reviewed 1/1/10
**VIP Claims Memo for Negotiations**  
HMO Illinois/ BlueAdvantage HMO

To: (CONTACT PERSON AT PROVIDING AGENCY)  
cc: ROCKFORD CLAIMS DEPT.  
(Barbara Thomas, Dawn Cunningham, Cora Pettigrew, Jeff Vanerio, Dawn Dunbar, Nikkia Wilson, Millie Brown, Tiffany Sorenson)

From: (Name of Nurse Liaison)

Subject: (Member’s name)  
Group/ID#:  
Provider Name: (Name of HHA, etc)  
Provider Contact Name:  
Negotiation Effective date: (start date)  
Contract Termination date: (end date)

**Billed charges will be paid at the Blue Cross and Blue Shield PPO fee schedule rate.**

Thank you for your assistance and cooperation in this matter. If you have any questions, please contact me, Nurse Liaison name and telephone number.

<table>
<thead>
<tr>
<th>Effective dates:</th>
<th>Payment Rate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______ through _________</td>
<td>Refer to the PPO fee schedule rate</td>
</tr>
</tbody>
</table>

**Number of visits per day/week:**

___ hours/_____ per day  
OR  
___ hours/_____ days per week

Name of Agency:

Revised 1/1/10
Policy Name: IPA Infertility Guidelines
Policy Number: Administrative 56
Effective Date: 8/1/00
Revision Date: 10/1/09

Policy:
The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) contract with a network of infertility practitioners to provide services to eligible members within the metro area. The HMOs are financially responsible for all infertility services and medication. The IPA Primary Care Physician (PCP) or Woman’s Principal Health Care Provider (WPHCP) should only refer members who have a diagnosis of infertility. Currently, WINFERTILITY INC, a division of Women’s Integrated Network (WIN), serves as the central point of contact for physicians, patients and pharmacies involved with infertility services.

Purpose/Objectives:
• To ensure qualified members receive appropriate benefits
• To provide IPAs with information to enable them to correctly diagnose and refer eligible members for infertility treatment.
• To comply with Illinois Department of Insurance guidelines regarding the coverage for infertility treatment

Guidelines:
“Illinois law requires insurance companies and HMOs to provide coverage for treatment. The law does not apply to self-insured employers or to trusts or insurance policies written outside of Illinois.” To receive infertility coverage, the member must meet the definition of infertility and not be voluntarily sterilized. Infertility is defined as:
• unable to conceive after one year of unprotected sexual intercourse between a male and female or
• unable to sustain a successful pregnancy
In the event a voluntary sterilization has been reversed successfully, infertility benefits will be available if the member’s current clinical situation meets the definition of infertility.

Non-Covered Services:
• Reversal of tubal ligation or vasectomy
• Donor and Surrogate fees
• Costs for medical services rendered to a surrogate for prenatal and childbirth purposes
• Transportation/shipping of donor sperm/egg
• Cryopreservation and storing of sperm, eggs or embryos
• Non-medical costs of an egg, sperm or embryo donor
• All investigational procedures, tests, treatments and drugs
• Costs for procedures which violate the religious and moral teachings or belief of the employer group
Procedure:

**DIAGNOSIS**

1. Infertility means the inability to conceive after one year of unprotected sexual intercourse between a male and female or the inability to sustain a successful pregnancy.

2. The one year time frame should be applied to women 36 and younger when establishing a primary diagnosis of infertility. However, a shorter time frame of six months should be used in the following circumstances:
   - Women older than 36
   - Women having unprotected intercourse with a male and who are not menstruating and/or have a cycle length of equal to or greater than 35 days
   - Women with Bilateral Tubal Occlusion based on HSG or prior surgery
   - Women who have had two or more ectopic pregnancies
   - Suspected Male factor infertility with either azoospermia or no motile sperm

3. General Evaluation must include the following:
   - Pap Smear
   - GC Culture
   - Chlamydia Culture
   
   Note: (A copy of the test results must be attached to the referral or given to the member. Infertility Providers will not see members without these test results)

4. Extended evaluation may include the following but is not required:
   - History and Physical
   - Semen Analysis
   - Hysterosalpingogram (HSG)
   - Cycle Day #3 Follicle Stimulating Hormone (FSH) and Estradiol (E2)
   - Thyroid Stimulating Hormone (TSH)
   - Prolactin
   - Mid Luteal progesterone
   - Preconception Counseling
   - Mammogram when appropriate
   
   Note: Infertility providers will be responsible for any portions of the evaluation not performed by the IPA or if tests are to be repeated.

5. Women with other gynecological problems such as minimal endometriosis (Stage 1 or Stage 2), fibroids, etc. should not be referred for infertility treatment until the WPHCP or PCP has attempted to treat these conditions.

**REFERRALS**

1. **New HMO Members and Existing Members requesting Services for the 1st time**
   These members must obtain a referral with a primary diagnosis of infertility from their PCP or WPHCP. IPAs must perform the general evaluation mentioned on the previous page prior to making the diagnosis of infertility.

2. **Existing HMO Members with global referrals requesting to change providers**
   Existing members who wish to obtain a second opinion or change to a new infertility provider will not have to obtain a new referral. However, to facilitate the transition, the member should obtain their medical records from their current provider prior to seeking services with a new provider.
3. **Catholic Directive and Catholic–Affiliated IPAs**

Catholic-Directive or Catholic–Affiliated IPAs that do not refer for infertility services should direct members to the HMOs’ Customer Assistance Unit (CAU) to assist them with obtaining a referral to a contracted provider in the WIN network.

4. **Time Period**

IPAs will issue a global referral for infertility services. Referrals will remain in effect for the duration of member’s existing insurance coverage. However, a member must meet the criteria for the diagnosis of infertility and receive a new referral following a live birth.

## MEDICATION

Members that do not have the HMO prescription drug benefit or an equivalent are entitled by law to receive infertility medication. Infertility medication must be obtained through a WIN contracted mail order pharmacy vendor, therefore, the infertility provider and/or member must contact WIN for authorization for their medication and/or applicable member reimbursement. WIN contracted vendors have access to the prescription drug system so they are able to verify eligibility and co-payment information prior to shipment. Members are responsible for the oral medication co-payment in most cases. Members can call WIN directly at 1-877-444-7299 for inquiries on their medications.

Lupron, which is not classified primarily as infertility medication, is subject to the self-injectable copayment.

Lupron-Depot is not a self-injectable. Providers must administer this injection. Lupron-Depot can be purchased through any of WIN’s contracted pharmacy vendors. Infertility providers and/or members need to contact WIN directly for authorization and/or applicable member reimbursement.

**Donor**

Medication for an egg donor is covered. The infertility provider and/or members requesting medication for a donor must contact WIN directly for authorization for their medication and/or applicable member reimbursement.

Other questions regarding specific infertility treatment should be referred to the patient’s infertility physician/or WIN.

## COPAYMENTS

*Copayments are applicable for physician office visits. Copayments are not applicable for infertility related services such as morning monitoring and lab tests.*

## BENEFIT INFORMATION

By state law, all members are eligible for the diagnosis and treatment of infertility. However some religious employer groups’ moral teachings and beliefs prohibit them from offering certain infertility treatment procedures to their employees. A list of employer groups that have limited infertility benefits are included in HMO Scope of Benefits section of the HMO’s provider manual. Please check this list prior to issuing referrals in order to provide Members thorough benefit information. This list may not be all inclusive so it is important to verify benefits prior to issuing a global infertility referral to the member.
EXHAUSTION OF LIMITED BENEFIT

State law allows four completed oocyte (egg) retrievals per person per lifetime regardless of source of payment. However, if a live birth occurs following a completed egg retrieval, only two additional completed oocyte retrievals will be allowed. Women’s Integrated Network (WIN), the HMOs’ infertility case management contractor, will notify HMO when a member has reached their maximum benefit or if services are requested for a member who doesn’t qualify for infertility treatment. Infertility providers will also verbally notify the Member of the exhaustion of benefits if applicable.

NETWORK PROVIDERS

The HMOs infertility network is listed on the BCBSIL website at www.bcbsil.com in the HMO provider section. Updated lists are available through your Provider Network Consultant or the BCBSIL website. If the medical group refers to a contracted WIN provider, WIN is financially responsible for authorized infertility services. If the medical group refers to a non-contracted WIN provider, the medical group is financially responsible for the infertility services.

CONTACT INFORMATION

WINFertility’s phone number is 1-877-444-7271 and their fax number is 1-877-369-4560

Members may also contact WINFertility directly at 1-877-444-7299 or HMO Member services at 1-800-892-2803 (Rockford HMO FSU) for assistance. The Customer Advocate staff will work with WINFertility to answer and resolve member inquiries. Staff will also track member inquiries and complaints for timely response and resolution from WINFertility to ensure compliance with NCQA guidelines.

HISTORICAL REFERENCE

1. Currently, WIN serves as the central point of contact for physicians, patients and pharmacies involved with infertility services.

2. January 1, 2003 - Full risk agreement reached between WIN and BCBSIL HMOs. WIN became financially responsible for all authorized infertility services and WIN managed pharmaceutical claims. The contracts between HMO and the infertility specialists were transferred to WIN, thereby, retaining the same network of providers.

3. February 1, 2000 - WIN, the HMO’s infertility case management contractor, began managing BCBSIL HMO infertility and related prescription drug services.

4. January 1, 2000 - The HMOs contracted with a network of infertility practitioners to provide services to eligible members. The HMOs were financially responsible for all infertility services and medication.

5. Prior to January 1, 2000 - The HMOs of BCBSIL capitated infertility services through one entity, Center for Human Reproduction (CHR).
Policy Name: Newborn IPA Selection  
Policy Number: Administrative-31  
Effective Date: 1/1/05  
Revised Date:  
Review Date: 12/1/09

Policy:  
Members of a Blue Cross and Blue Shield of Illinois (BCBSIL) HMO can split their IPA/Independent Physician Association (IPA) affiliation between family members. The IPA responsible for treating and coordinating care of a newborn from birth until discharge from the hospital will be the mother’s Primary Care Physician (PCP)/Women’s Principal Health Care Provider (WPHCP) site. The IPA responsible for treating and coordinating care of a newborn post discharge will be the Pediatric IPA.

Purpose/Objectives:  
• To assure timely payment of services provided to newborns.  
• To assure IPA accountability related to newborn care.  
• To assure newborn clinic changes are handled in a manner consistent with the HMO IPA Change policy.

Guidelines (for Dates of Birth as of 1/1/05):  
Accountability and Payment Responsibilities  
- Inpatient services – the mother’s PCP/WPHCP IPA is responsible for coordination and payment as authorized by the mother’s PCP/WPHCP IPA for covered services from the date of birth through the date of discharge (and any immediate follow up outpatient care at the mother’s hospital), including professional and institutional services, and including any transfer of the newborn to a tertiary or other facility (considered part of the initial hospital stay).

- Outpatient services – the Pediatric IPA is responsible for coordination and payment as authorized by the Pediatric IPA for covered services post discharge, including professional and institutional services rendered subsequent to the initial discharge if the child is added to the HMO policy.
Newborn MG/IPA Selection
Page 2 of 4

Procedure:

1. The PCP/WPHCP IPA is responsible for creating an eligibility record for the newborn for purposes of pre-certifying the delivery and/or authorizing and paying for services related to the newborn’s inpatient care (and any services rendered on an outpatient basis by mother’s hospital immediately post discharge). The PCP/WPHCP IPA is prepaid for these services, and in the event the mother selects a different site for the newborn’s Pediatric IPA, there will not be an eligibility record created by HMO for the newborn for the PCP/WPHCP site.

2. The Employer submits enrollment information within 31 days of newborn’s birth. In the event the mother calls Customer Service prior to delivery, Customer Service should give proper instructions on how to add the newborn and document information on the Inquiry Reporting and Information System.

3. HMO Membership will add the newborn to the IPA enrollment retroactively to the date of birth to the Pediatric IPA selected (for enrollment which is obtained electronically, this process is automatic). Retroactive capitation is paid accordingly and capitation represents prepayment for services rendered subsequent to discharge for the delivery.

4. Inpatient claims for services generated by the PCP/WPHCP IPA for services related to the delivery should be identified with the mother, so that HMO can identify and route inpatient and professional claims to PCP/WPHCP IPA for Group Approval (GA) and/or payment.

5. Outpatient claims for services generated by the Pediatric IPA for services provided post discharge should be identified with the new member’s correct name and ID number, so that HMO can identify and route professional claims and/or inpatient claims subsequent to the initial hospitalization to the Pediatric IPA for GA and/or payment (Pediatricians and others should be advised to hold claims until the correct member identification information can be provided, otherwise the claims will be returned as unidentifiable).

Attachment: Newborn Situation Chart
<table>
<thead>
<tr>
<th>Newborn Situation</th>
<th>HMO will:</th>
<th>IPA will:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Policy:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prior to Baby being added to policy:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Bill:</td>
<td>Adjudicate Inpatient Facility for Date of Service (DOS) &lt;= 31 days; no payments made for &gt; 31 days until/if baby added</td>
<td>GA the Inpatient stay (1)</td>
</tr>
<tr>
<td>Inpatient Professional Claims*</td>
<td>Forward to mother's IPA</td>
<td>Adjudicate claims rec'd directly and forwarded by BCBS (prepaid for svc) for DOS &lt;= 31 days; no payments made for DOS &gt; 31 days until/if baby added</td>
</tr>
<tr>
<td>Outpatient Professional Claims:</td>
<td>Forward to mother's IPA</td>
<td>Adjudicate claim to IPA provider indicating waiting for confirmation of eligibility and not to bill member; if not IPA provider then return to BCBS NGA</td>
</tr>
<tr>
<td><strong>Family Policy:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>After Baby added to policy:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Bill:</td>
<td>Adjudicate Inpatient Facility</td>
<td>GA the Inpatient stay (1)</td>
</tr>
<tr>
<td>Inpatient Professional Claims*:</td>
<td>Forward to Pediatric IPA</td>
<td>Adjudicate claims if Ped site = mother's site; if not mother's site return claim to BCBS &quot;Non Group Approval&quot; (NGA) Mother's site liability***</td>
</tr>
<tr>
<td>Outpatient Professional Claims:</td>
<td>Forward to Pediatric IPA</td>
<td>Adjudicate claims</td>
</tr>
</tbody>
</table>
### Newborn MG/IPA Selection

**Page 4 of 4**

<table>
<thead>
<tr>
<th>Newborn Situation</th>
<th>HMO will:</th>
<th>IPA will:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single Policy:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prior to Baby being added to policy:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Bill:</td>
<td>Adjudicate Inpatient Facility for DOS &lt;= mother’s stay for baby; no payments made for DOS &gt; mother’s stay until/if baby added</td>
<td>GA the Inpatient stay (1)</td>
</tr>
<tr>
<td>Inpatient Professional Claims*:</td>
<td>Forward to Mother’s IPA</td>
<td>Adjudicate claims rec’d directly and forwarded by BCBS (prepaid for svs) for DOS &lt;= mother’s stay for baby; no payments made for DOS &gt; mother’s stay until/if baby added</td>
</tr>
<tr>
<td>Outpatient Professional Claims:</td>
<td>Deny the claim until/if added to policy</td>
<td>Deny the claim to providers indicating claim will be paid if newborn added to policy; if newborn added pay claims according to Family Policy process</td>
</tr>
<tr>
<td><strong>Single Policy:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>After Baby added to policy:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Bill:</td>
<td>Pay Inpatient Facility</td>
<td>GA the Inpatient stay (1)</td>
</tr>
<tr>
<td>Inpatient Professional Claims*:</td>
<td>Forward to Pediatric IPA</td>
<td>Adjudicate claims if Ped site = mother's site; if not mother's site return claim to BCBS &quot;NGA Mother's site liability&quot;**</td>
</tr>
<tr>
<td>Outpatient Professional Claims:</td>
<td>Forward to Pediatric IPA</td>
<td>Adjudicate claims</td>
</tr>
</tbody>
</table>

---

1. GA status for newborn should be provided when the Mother’s IPA provided GA status for the maternity stay; only when the maternity stay was NGA would a NGA status on the newborn be appropriate; if GA provided on maternity stay HMO will assume GA for newborn.

* This is for continuous hospitalization(s) from Date of Birth (DOB) and includes any post discharge lab, misc provided by hospital as part of inpatient stay. If baby is not added to policy after 31 days from the DOB, claims will not be adjudicated until baby is added to the policy.

**(**) Inpatient claims will be routed to mother's site for payment; if no mother's site i.e. added to dad's policy HMO will pay responsible charges for inpatient DOS <= mother’s stay for baby after mother’s insurer, if any, pays.

NOTE: Dependant of dependant (grandchild) handled same as Family policy when coverage for grandchildren is provided, otherwise handle as Single policy. This also applies to adoption cases.

Reviewed 12/1/09
Policy Name: Utilization Management Fund Challenge
Policy Number: Administrative - 66
Effective Date: 6/1/02
Revision Date: 7/1/09

Policy:
The HMOs of Blue Cross and Blue Shield of Illinois calculate the Final Utilization Management (UM) Fund annually. Units charged against the UM Fund are based on the claim information submitted by the provider of the services. The actual units charged are determined by the type of claim, type of provider, and the dates of service. The Independent Physician Association (IPA) will have one year from the date of the distribution to submit a written challenge of the units charged on their Final UM Fund.

Purpose/Objective:
- To allow the IPA a means to contest the actual units charged.
- To reimburse to the IPA any funds withheld as a result of an error by the HMOs.
- To limit final UM Fund challenges to the number of units charged.
- To ensure all IPA UM Fund concerns are documented and addressed.

Procedure:
When an IPA has a dispute of the actual units charged on their UM Fund, the following steps should be taken prior to submitting as a Challenge:

1. The IPA must submit a UM Fund Challenge within one year of receipt of the UM Fund report.

2. Verify the 095 report to determine if claim was originally submitted as group approved.

3. Review policy to determine if the challenge reason is appropriate to send to the HMOs. (For example- see list of reasons where HMO response is ‘no credit given’ located at the end of this section.)

4. Use the electronic file provided by HMO, insert a column, type in the reason for the challenge and return the file including supporting documentation to HMO.

Following are examples of the most common challenge scenarios and the manner in which they will be handled by the HMOs:
### Challenges handled with no claim re-adjudication:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Required Action/Documentation by IPA</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Units charged at the non-contracted rate. IPA called prior to the services rendered and received authorization by HMOs to use the non-contracting provider.</td>
<td>Submit the written exception form provided by the HMOs.</td>
<td>Penalty units will be removed.</td>
</tr>
<tr>
<td>Units charged at the non-contracted rate. IPA states provider is on Appendix D.</td>
<td>Provide the Appendix D with the provider listed at the time of service.</td>
<td>If provider is on Appendix D, penalty units will be removed.</td>
</tr>
<tr>
<td>Inpatient services were for chemical dependency (Metro area only).</td>
<td>Document services are for chemical dependency.</td>
<td>Units will be credited if claim documentation substantiates that services were for chemical dependency.</td>
</tr>
<tr>
<td>Stop Loss was not calculated correctly.</td>
<td>Provide a list of the claims that should be included in the calculation.</td>
<td>Stop loss will be recalculated.</td>
</tr>
</tbody>
</table>
### Challenges handled through claim re-adjudication:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Required Action/Documentation By IPA</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider bills using the wrong provider number and this results in the wrong number of units being charged (e.g., provider bills using the provider number assigned for acute care but services were rendered in a SNF or rehab units).</td>
<td><strong>IPA must request</strong> Provider to re-submit bill and refund payment to Rockford claims with the correct provider number.</td>
<td>Penalty units will be credited when the provider re-bills with the correct provider number and refunds the payment. Correction will appear on next UM Fund after the adjusted bill is processed.</td>
</tr>
<tr>
<td>Units charged but member is secondary, or services should be paid by third party.</td>
<td>Provide other carrier information to HMOs.</td>
<td>HMOs will investigate and units will be credited when and if other carrier pays more than 50% of the billed charges.</td>
</tr>
<tr>
<td>Services were ‘Out of Area’ (OOA) and the place of treatment was more than 30 miles from the IPA address.</td>
<td>Provide documentation that the place of treatment was more than 30 miles from IPA address and no IPA affiliated physician approved or referred services.</td>
<td>Units will be reversed if documentation substantiates OOA.</td>
</tr>
<tr>
<td>IPA states services were not group approved and no affiliated physician admitted or referred for the services.</td>
<td>Provide copy of IPA EOB that was sent to the member or provider, which states that services were not group approved. Also, other claims related to the specified date of service must have been submitted to the HMO by the IPA to deny as NGA by the HMOs.</td>
<td>Units will be reversed if documentation substantiates NGA.</td>
</tr>
</tbody>
</table>
## Miscellaneous Challenges:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPA states that services were for observation room only. (This applies to claim with date of service prior to 1/1/2002)</td>
<td>IF UM Fund claim report shows a COR code of “3” for the claim, then the provider submitted the bill as OP Surgery and units will not be reversed.</td>
</tr>
<tr>
<td>Effective 1/1/2002 – Observation room only</td>
<td>Units will be charged for all observation room outpatient services.</td>
</tr>
<tr>
<td>Units charged for late discharge</td>
<td>If HMOs are billed for a late discharge, units will be charged.</td>
</tr>
<tr>
<td>Penalty applied for office procedure performed in an alternate setting for claims with a date of service after 12/31/2004.</td>
<td>Provide a copy of the UM exception approved by HMO otherwise no credit given.</td>
</tr>
<tr>
<td>IPA states services were not group approved (NGA). If approval was determined by one of the following processes:</td>
<td>Then:</td>
</tr>
<tr>
<td>Claim submitted with GAP by provider</td>
<td>No credit given</td>
</tr>
<tr>
<td>Claim stamped group approved by IPA</td>
<td>No credit given</td>
</tr>
<tr>
<td>Group Approved on the daily status report</td>
<td>No credit given</td>
</tr>
<tr>
<td>Verbal approval given to an HMO representative</td>
<td>No credit given</td>
</tr>
<tr>
<td>IPA did not return GA daily status report within the designated timeframe</td>
<td>No credit given</td>
</tr>
<tr>
<td>Group Approved the 095 report</td>
<td>No credit given</td>
</tr>
<tr>
<td>In house approval</td>
<td>No credit given if PCP is listed as the attending physician on the UB04 or the hospital is listed as one of the IPA admitting facilities</td>
</tr>
<tr>
<td>ER admit (effective 1/1/00)</td>
<td>No credit given</td>
</tr>
<tr>
<td>No proof of above but no related services were submitted as NGA by IPA</td>
<td>No credit given</td>
</tr>
</tbody>
</table>
### Policy: A Woman’s Principal Healthcare Provider

The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) will offer female members both choice and direct access to all marketed Woman’s Principal Healthcare Providers (WPHCPs) within the HMO network.

### Purpose/Objectives:

- A WPHCP is a physician licensed to practice medicine in all its branches specializing in obstetrics and gynecology or family practice, and who may also choose to act as a Primary Care Physician (PCP), practicing medicine outside the scope of OB/GYN services.
- To assure female HMO members the right to access the WPHCP of their choice.
- To assure Independent Physician’s Association (IPA) accountability for WPHCP care.

### Procedure:

1. A WPHCP may be seen for care without referrals from the PCP. However, the PCP and the WPHCP must have a referral arrangement with one another.

2. As part of their enrollment, all members must select a PCP IPA for routine services. In addition, female members also may choose a WPHCP.

3. Female members may access their designated WPHCP without obtaining referrals from their PCP.
Policy Name: Member Access to Behavioral Health Services
Policy Number: Administrative-64
Effective Date: 1/1/01
Revised Date: Review Date: 11/1/09
Approval Signature:

Senior Medical Director
Vice President– Network Management
HMOI, BlueAdvantage HMO
Approved QI: 11/4/09
Approved P&P: 10/29/09

Policy:

Behavioral Health services must be provided to all members in accordance with the established access standards. All Independent Physician Associations (IPA) must have a written policy and procedure in place addressing the process of accessing behavioral health services, whether the management of the services is delegated or performed within the IPA. This policy is applicable to behavioral health services only. Chemical dependency services are provided through Magellan Behavioral Health.

Purpose/Objectives:

- To establish guidelines for service availability for behavioral health care
- To establish guidelines for telephone access to behavioral health services where there is centralized triage and referral process in place

Procedure:

A. Behavioral Health services must be provided in accordance with the following access standards with written documentation provided to the HMO as requested:
   1. Access to care for life-threatening emergency immediately
   2. Access to care for non-life threatening emergency within six hours of request
   3. Access to urgent care within 24 hours of request
   4. Access to an appointment for a routine office visit or initial evaluation within 10 business days or two weeks of request, whichever is sooner

B. In addition, the following are required when centralized triage and referral are applicable:
   1. Telephone answered by non-recorded voice within 30 seconds
   2. Abandonment rate (the percentage of phone calls where member disconnected before the call was answered) less than five percent

C. The policy and procedure of the IPA must meet the following HMO access standards for behavioral health services:
   1. Provide and/or refer for life-threatening emergency care immediately
   2. Provide and/or refer for non-life-threatening emergency care within six hours of request
   3. Schedule and provide urgent care within 24 hours of request
   4. Schedule routine appointments or initial evaluation within 10 business days or within two weeks of request, whichever is sooner
   5. Arrange for an answering system after office hours that members can access through the usual office protocol:
      - Response to emergency phone calls should be within 30 minutes
Member Access to Behavioral Health Services
Page 2 of 2

- Response to urgent phone calls should be within one hour
- For life-threatening emergencies, members should be referred to the appropriate Health Care Facility

D. In addition to the above standards, the policy and procedure of IPAs with centralized screening and triage must also meet the following HMO access standards for behavioral health services. Arrange for telephone access to screening and triage, if applicable, as follows:
  - Callers reach a non-recorded voice within 30 seconds
  - Abandonment rates do not exceed five percent at any given time

E. Any Behavioral Health Organization or IPA providing behavioral health services must submit telephone reports quarterly to the Blue Cross Blue Shield of Illinois Quality Improvement Department. The reports must include the average speed of answer and the call abandonment rate.

F. For IPAs that are unable to separate behavioral health telephone statistics from medical, combined telephone statistics are acceptable. IPAs with telephone systems that cannot report telephone statistics must notify the HMO in writing about system limitations.

G. The HMO may monitor compliance with the centralized triage and referral guidelines through review of any of the following:
   1. Annual evaluation of the Utilization Management (UM) Plan
   2. Annual UM adherence audit
   3. Quarterly Contract Management Firm Report, if applicable
   4. HMO member satisfaction surveys
   5. Member complaints
   6. Telephone audits performed by the HMO to monitor behavioral health access standards
   7. Telephone reports related to HMO access standards
Policy:
The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) will ensure timeliness of Primary Care Physician (PCP) and Women’s Principal Healthcare provider (WPHCP) access standards for the benefit of its members.

Purpose/Objectives:
To ensure that members have reasonable access to medical services.

Procedure:
A. All Independent Physician Associations (IPAs) must provide reasonable access for Members enrolled with the IPA, including, but not limited to the following:
   1) extended visits (i.e. comprehensive exam, preventive care appointment) within four weeks of request;
   2) routine appointments within 10 business days or two weeks of request, whichever is sooner;
   3) non-urgent, symptomatic appointments within four calendar days of request;
   4) urgent appointments within 24 hours of request; and
   5) response by IPA Physicians to an emergency call within 30 minutes of an emergency call.

B. The IPA shall also assure that HMO Members enrolled with the IPA have reasonable access to an IPA Physician by providing:
   1) evening or early morning office hours three or more times per week;
   2) weekend office hours two or more times per month; and
   3) notification to the Member when the anticipated office wait time for a scheduled appointment may exceed 30 minutes;
   4) a 24-hour answering service and assure that each PCP and WPHCP provides a 24-hour answering arrangement, including a 24-hour on-call arrangement for all members.

C. The access audit will be conducted in accordance with the current Quality Site Visit Standards Policy.
Policy Name: Centralized Triage and Referral for Behavioral Health Care
Policy Number: Administrative-62
Effective Date: 1/1/01
Revision Date: Review Date: 11/1/09

Approval Signature: [Signatures]

Senior Medical Director
Vice President– Network Management
HMOI, BlueAdvantage HMO

Policy:

Blue Cross and Blue Shield of Illinois (BCBSIL) has established guidelines for Independent Physician Association (IPA) that have a non-delegated or delegated centralized triage and referral process for behavioral health care. This policy is applicable to behavioral health services only. Chemical dependency services are provided through Magellan Behavioral Health.

Purpose/Objectives:

- To ensure appropriate access to behavioral health services.
- To establish guidelines for IPAs that have a centralized triage and referral process for behavioral health services.
- To establish oversight guidelines for IPAs that sub-delegate management of behavioral health services.

Procedure:

A. All IPAs with centralized triage and referral of behavioral health services must have a process in place which includes the following:

1. Triage and referral protocols address the level of urgency and appropriate setting for care,
2. Triage and referral protocols are based on sound clinical evidence and currently accepted industry practices, and are reviewed or revised annually,
3. Non-clinical decisions are made by staff with appropriate professional experience,
4. Clinical triage and referral decisions are made by licensed behavioral health care practitioners
5. Staff making clinical decisions are supervised by a licensed practitioner with a minimum of a master’s degree and five years of post-master’s clinical experience,
6. Triage and referral decisions are overseen by a licensed psychiatrist or an appropriately licensed doctoral-level clinical psychologist.

B. IPAs that have a centralized triage and referral process for behavioral health services will:

1. Have a written policy and procedure addressing the guidelines established for a centralized triage and referral process for behavioral health services,
2. Maintain a centralized telephone triage and referral system, which is appropriately implemented, monitored and professionally managed.
3. Monitor behavioral health activities, including but not limited to utilization statistics, telephone reports, member satisfaction surveys, member complaints, as well as any other activities deemed appropriate by the IPA, to ensure that all activities are being conducted in accordance with HMO standards.

C. IPAs that sub-delegate management of behavioral health services will monitor the sub-delegated entity for compliance with the established guidelines through review and documentation of the following:

1. Annual review and evaluation of the sub-delegated entity’s Utilization Management Plan,
2. Annual review of the sub-delegated entity’s telephone triage and referral system, implementation and management of the process,
3. Quarterly review and evaluation of the sub-delegated entity’s activities, including but not limited to utilization statistics, telephone reports, member satisfaction surveys, member complaints, as well as any other activities deemed appropriate by the IPA, to ensure that all activities are being conducted in accordance with the IPA expectations.

D. The HMO may monitor compliance with the centralized triage and referral guidelines through review of any of the following:

1. Annual evaluation of the UM Plan
2. Annual UM adherence audit
3. Quarterly Contract Management Firm (CMF) Report, if applicable
4. HMO member satisfaction surveys
5. Member complaints
6. Telephone audits performed by the HMO to monitor behavioral health access standards
7. Telephone reports related to HMO access standards
Policy:  

The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) require a Corrective Action Plan from an Independent Physician Association (IPA) as a result of a failed Utilization Management (UM) adherence audit.

Purpose/Objectives:

- To ensure compliance with the UM Plan of the HMOs of BCBSIL.
- To ensure the correction of any UM deficiencies.

Procedure:

1. The HMO Nurse Liaison performs the UM adherence audit annually. The adherence audit results are provided to the IPA at the time of the audit.

2. IPAs that have not received a passing score above 90% are required to provide a Corrective Action Plan within 60 days of the date on the audit results letter addressing the deficient areas. The IPA shall direct all requests for assistance concerning the Corrective Action Plan to the HMO Nurse Liaison.

3. The Corrective Action Plan must meet guidelines established by the HMO and shall include the following:

   - A statement of the deficiency/deficiencies being addressed.
   - A description of the steps which will be taken to correct the cited deficiencies.
   - Timeframes for performing key steps in the corrective action plan process, including start-up and completion dates.
   - Identification of the responsible parties for implementing and overseeing the corrective action process.
   - A description of the new/revised procedures that will be implemented to prevent reoccurrence of the cited deficiency/deficiencies.
   - Plans for monitoring compliance with revised procedures, including identification of the individual(s) responsible for oversight.
   - Acknowledgment of the HMO planned re-audit.
   - The signature of the IPA Medical Director.
4. When the Corrective Action Plan is received, it is reviewed by the Nurse Liaison for completeness and for compliance with HMO requirements.

5. Once the Corrective Action Plan has been approved by the HMO, IPA compliance should be documented in the UM/Quality Improvement committee minutes.

6. If the Corrective Action Plan is not received by the HMO within the 60 day period, an Administered Complaint will be issued.

7. If a Corrective Action Plan is not received within an additional two weeks, another Administered Complaint will be issued and a meeting with HMO and IPA Management will be required to discuss the corrective action process.

8. A monthly audit will be performed for a period up to three to six months after the date of the annual audit, based on the nature of the deficiencies and recommendations of the HMO Nurse Liaison. At the end of this audit, there will be a cumulative score that will apply to the next annual audit.

9. If the re-audit results in a failure, the following will occur:
   - An Administered Complaint will be issued.
   - The HMO Nurse Liaison, HMO Medical Director, Director and/or UM Manager will meet with the IPA’s senior management to discuss additional corrective action. One or more of the following may occur: closing the IPA to new enrollment, sending an HMO representative to their UM monthly meeting, outsourcing UM to a reputable Contract Management Firm (CMF), sending of additional documentation or other activities as deemed necessary by HMO.

10. If the IPA fails the next annual UM compliance audit, the following steps will take place:
    - HMO files an Administered Complaint.
    - HMO Management will consider the issuance of a Medical Service Agreement (MSA) default letter. If a default letter is sent, the IPA will have 60 days to cure the default, otherwise the IPA will be departicipated from the network.
    - One or more of the following may occur: closing the IPA to new enrollment, sending an HMO representative to their UM monthly meeting, outsourcing UM to a reputable CMF, sending of additional documentation or other activities as deemed necessary by HMO.

11. The QI Fund payment for the UM Annual Adherence Audit may still be received if the corrective action is completed and approved before the QI Fund payment is processed.
Policy

The HMOs of Blue Cross and Blue Shield of Illinois require all Independent Physician Associations (IPAs) to comply with the State of Illinois requirements that all Utilization Review Organizations (URO) performing utilization management in Illinois register with the Department of Insurance, and be accredited by or be in compliance with URAC Health Utilization Management Standards. Every IPA must register with the state as a utilization review organization. In addition, if an IPA sub-delegates utilization management, the IPA must verify that the delegate organization meets these requirements.

Purpose:

To ensure IPA compliance with State of Illinois legislation.

Definitions:

Utilization Management: includes, but is not limited to prospective, initial, concurrent and retrospective review of medical services; referrals, case management and/or discharge planning.

Procedure:

1. Each IPA is required to register with the Illinois Department of Insurance and notify the HMO of its’ URO registration status.

2. Verification of the URO status (initial registration and re-registration) is done at the time of the annual UM Plan Submission Audit.

3. If the IPA delegates its’ UM functions, the IPA must verify that the delegated organization is in compliance with these standards, identify this delegated entity to the HMO along with verification of the delegated organization’s URO registration status.

4. IPAs and IPA delegates must keep their URO registration current. A re-registration is required every two years as indicated by the Illinois Department of Insurance. The HMO Nurse Liaisons will verify if the IPA has re-registered via the state web site, if no documentation is available from the state.
Policy Name: Utilization Management Adherence Audit of Participating IPAs
Policy Number: Administrative-60
Effective Date: 1/1/00
Revision Date: 1/1/10

Policy:

The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) will perform an Annual Utilization Management (UM) Adherence Audit of participating Independent Physician Association (IPAs). The audited items are identified in the Utilization Management Adherence Audit Tool. The tool includes the evaluation of UM Committee Activity and Case File Review which is updated annually (Attachment A – 2009 UM Adherence Audit Tool).

Purpose:

To ensure IPAs effectively perform UM Activities and are in compliance with HMO requirements.

Guidelines:

Each standard has specific scoring criteria as identified in the UM Adherence Audit Tool. Any new items introduced into the audit are not scored, but may be scored the following audit year.

Procedure:

The HMO Nurse Liaison performs the audit of IPA UM activities. The UM Adherence Audit Tool (Attachment A) is used to measure compliance with HMO UM requirements. Audit scoring methods are reviewed with the IPA at the time of the audit. The IPAs receive a written report at the time of the audit.

Audit Requirements

The HMOs of BCBSIL require a compliance score of at least ninety (90) percent for the annual Adherence Audit, which includes UM Committee Activity Review and Case File Review.
# Attachment A

## 2010 Utilization Management Committee Activity

<table>
<thead>
<tr>
<th>IPA #</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Liaison:</td>
<td></td>
</tr>
</tbody>
</table>

Member survey by IPA score for referral question: _______  <83 REQUIRES INTERVENTION  
PCP survey score for PCP referral question: _______  <83 REQUIRES INTERVENTION

### MONTHLY REQUIREMENTS (10) (1 pt for each meeting)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair/members present listed AND Members present match with list in IPA UM Plan (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Physicians at meeting (TOTAL): (10) # Specialists at meeting (1 OR &gt;): (1 pt for each meeting if at least 1 specialist present)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minutes signed within 5 weeks of last meeting (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Denials/Appeals

Denials reported consistent with log, include summary of categories (medically necessary, out-of-network, benefit), number in each category (5)

Appeals reported consistent with log, include summary of categories (medically necessary, out-of-network, benefit), number in each category (5)

Document number of inpatient case PA referrals and the number resulting in denial. (5)

### QUARTERLY REQUIREMENTS

#### Complaints

Complaints match log (3 months), number documented in minutes (include category, such as: access, referrals, PCP), resolution documented, timeframe met. Include BH. If no complaints, must be noted. (2)

#### CMF Reporting

Quarterly reports reviewed and discussed, including delegated BH and telephone reports, if applicable (2)

#### Denial File Results

Discussion of quarterly denial file results from HMO, any non-compliance and corrective action, if applicable (2)

### SEMI-ANNUAL REQUIREMENTS

#### Utilization Statistics

Track/trend utilization data (min 4 areas, including 1 BH) for 6 months or 2 qtrs compared (5)
<table>
<thead>
<tr>
<th>Task</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discussion of trend, issues, planned interventions</strong></td>
<td>(5)</td>
</tr>
<tr>
<td><strong>Discussion of 6 month summary of avoidable days, reasons for delayed discharge, and any IPA physician patterns. Include corrective action for physicians with identified patterns.</strong></td>
<td>(5)</td>
</tr>
<tr>
<td><strong>Referrals</strong></td>
<td></td>
</tr>
<tr>
<td>2 Qtrs or 6 months of data in graph or table format for specialty (any identified and total), out of network, BH referrals (total) documented/maintained.</td>
<td>(5)</td>
</tr>
<tr>
<td><strong>Discussion of trend, issues, planned interventions</strong></td>
<td>(5)</td>
</tr>
<tr>
<td><strong>Inter- rater Reliability</strong></td>
<td></td>
</tr>
<tr>
<td>Inter-rater for medical criteria for UM staff, includes # cases, # staff reviewed, results, discussion of corrective action. <strong>All UM staff must be included</strong></td>
<td>(5)</td>
</tr>
<tr>
<td>Inter-rater for medical criteria for Medical Director, Pas, includes # cases, # staff reviewed, results, discussion of corrective action. <strong>All physicians must be included</strong></td>
<td>(5)</td>
</tr>
<tr>
<td>Inter-rater for UM decision-making timeframes. Summary of # staff reviewed, # cases, results and discussion of corrective action. <strong>All UM staff must be included</strong></td>
<td>(5)</td>
</tr>
<tr>
<td><strong>ANNUAL REQUIREMENTS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>UM Plan</strong></td>
<td></td>
</tr>
<tr>
<td>Review and approval of IPA UM Plan, including BH (5) OR if Delegated BH – include approval of BH UM Plan</td>
<td>Date:</td>
</tr>
<tr>
<td><strong>Medical Criteria</strong></td>
<td></td>
</tr>
<tr>
<td>Review and acceptance of nationally recognized medical criteria (5)</td>
<td>Date:</td>
</tr>
<tr>
<td>Nationally recognized criteria used (current):</td>
<td></td>
</tr>
<tr>
<td>Review and approval of IPA additional criteria, guidelines, clinical pathways, etc. if applicable. Must include how developed and policy for use.</td>
<td>Date:</td>
</tr>
<tr>
<td>Review and approval of BH criteria (5)</td>
<td>Date:</td>
</tr>
<tr>
<td><strong>BH criteria used:</strong></td>
<td></td>
</tr>
<tr>
<td>Medical Criteria (including BH) matches UM Plan</td>
<td></td>
</tr>
<tr>
<td>Additional Criteria matched UM Plan</td>
<td></td>
</tr>
<tr>
<td><strong>UM Program Evaluation</strong></td>
<td></td>
</tr>
<tr>
<td>Review and evaluation of UM program (5)</td>
<td>Date:</td>
</tr>
<tr>
<td>Goals identified in UM Plan discussed/approved (5)</td>
<td></td>
</tr>
<tr>
<td>Review and discussion of goals match UM plan (2)</td>
<td></td>
</tr>
<tr>
<td>Evaluation of planned interventions for each goal, results, opportunities for improvement. New goals identified. (5)</td>
<td></td>
</tr>
<tr>
<td><strong>Review of UM Policy and Procedures</strong> (5 for applicable)</td>
<td></td>
</tr>
<tr>
<td>UM staff onsite at facility, if applicable</td>
<td>Date:</td>
</tr>
<tr>
<td>Staff orientation/ training/ performance review</td>
<td>Date:</td>
</tr>
</tbody>
</table>
### Diagnoses, procedures, physicians not requiring pre-certification and/or concurrent review, if applicable

| Date: |

### Additional criteria, clinical pathways, guidelines used for UM decision-making and the process for development and approval, if applicable

| Date: |

### Case closure due to insufficient information

| Date: |

### Standing referrals

| Date: |

### Appeals

| Date: |

### PHI

| Date: |

### Confidentiality

| Date: |

### Information systems, security, integrity, storage, disaster recovery

| Date: |

### Tracking avoidable days for IPA physicians and method for corrective action and non-compliance

| Date: |

### Hospitalist, Practitioner Rounder Program if applicable

| Date: |

### PCP Notification of Member of Approved Certification if applicable

| Date: |

### Case Management

| Date: |

### Reporting

- Score for satisfaction with referral process noted (1)

- Review and discussion of HMO PCP UM Survey results with interventions if referral question less than 83% (2)

- Score for satisfaction with referral process noted (1)

- Review and discussion of HMO member survey by IPA referral question results with interventions if referral question less than 83% (2)

Total possible score: 134  (Excluding CMF not applicable = 132)
II. CASE FILE REVIEW

The Nurse Liaison will choose at least twenty cases from the IPA admission logs while on site including complex case management files. The files will be chosen to reflect: four emergent, four concurrent, two behavioral health initial, two behavioral health concurrent, two skilled nursing facility, two home health, two cases with referrals to the physician advisor, and two long stay cases. Any type of case which is not available will be replaced with another type of case. The cases will be chosen from the last six months prior to the audit. Twenty cases will be reviewed to determine the IPA case file score (272 points). Cases can be reviewed at the time of audit for assessment of the Hospitalist Program Criteria. Automatic audit points may be achieved with documented Hospitalist Program requirements (twice daily visits, AM and PM, by PCP or Hospitalist).

**Emergent (Initial) - 4 cases, 2 pts each box, total 64**

<table>
<thead>
<tr>
<th>Case</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review/cert. form completed within 24 hours of receipt of request</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Clinical documented with source</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Estimated length of stay documented (original and additional)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Medical criteria including code</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Member and Practitioner notification within time frame</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>All required elements documented: patient name, Patient ID, date of review, name of physician(s), diagnosis, procedure, admit date, facility name</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Discharge planning initiated on initial review, potential plan documented</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Home, family, environment assessment on initial review</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
| Case was reviewed by PCP or hospitalist in AM and PM every day of stay | ☐ | ☐ | ☐ | ☐

**Concurrent - 4 cases, 2 pts each box, total 56**

<table>
<thead>
<tr>
<th>Case</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>First concurrent review form completed within 24 hours of receipt of request</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Utilization Management Adherence Audit of Participating MG/IPAs
Page 6 of 10

Subsequent concurrent reviews 1 day prior to end of additional length of stay assigned
☐ ☐ ☐ ☐ [NA ☑]

Clinical documented with source
☐ ☐ ☐ ☐

Additional estimated length of stay
☐ ☐ ☐ ☐ [NA ☑]

Medical criteria including code
☐ ☐ ☐ ☐

Practitioner notification within time frame, or IPA policy assumes approval
☐ ☐ ☐ ☐

Discharge need documented prior to estimated discharge date
☐ ☐ ☐ ☐

FOR NURSE LIASON USE:

PATIENT COULD HAVE BEEN DISCHARGED EARLIER
☐ ☐ ☐ ☐

CRITERIA WAS STALLED, NO NEW CRITERIA NOTED
☐ ☐ ☐ ☐

REFERRAL TO PA WITHOUT CRITERIA RESULTED IN APPROVAL, SEEMED APPROPRIATE
☐ ☐ ☐ ☐

REFERRAL TO PA WITHOUT CRITERIA RESULTED IN APPROVAL, SEEMED INAPPROPRIATE
☐ ☐ ☐ ☐

REFERRAL TO PA LED TO DISCHARGE
☐ ☐ ☐ ☐

Case was reviewed by PCP or hospitalist in AM and PM every day of stay
☐ ☐ ☐ ☐ [NA ☑]

Behavioral Health Emergent (Initial) - 2 cases, 2 pts each box, total 32
(If no behavioral health cases available, choose medical emergent cases)

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review/ cert. form completed within 24 hours of receipt of request</td>
<td>☐</td>
</tr>
<tr>
<td>Clinical documented with source</td>
<td>☐</td>
</tr>
<tr>
<td>Estimated length of stay documented (original and additional)</td>
<td>☐</td>
</tr>
<tr>
<td>BH criteria including code</td>
<td>☐</td>
</tr>
<tr>
<td>Practitioner notification within time frame</td>
<td>☐</td>
</tr>
</tbody>
</table>
Utilization Management Adherence Audit of Participating MG/IPAs
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All required elements documented: patient name, patient ID, date of review, name of physician(s), diagnosis, procedure, admit date, facility name

| Discharge planning initiated on initial review, potential plan documented | ☐ | ☐ |
| Home, family, environment assessment on initial Review | ☐ | ☐ |
| Case was reviewed by PCP or hospitalist in AM and PM every day of stay | ☐ | ☐ | NA ☐ |

**Behavioral Health Concurrent - 2 cases, 2 pts each box, total 28**

(If no BH, choose medical concurrent)

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>First concurrent review form completed within 24 hours of receipt of request</td>
<td>☐</td>
</tr>
<tr>
<td>Subsequent concurrent reviews 1 day prior to end of additional length of stay assigned</td>
<td>☐</td>
</tr>
<tr>
<td>Clinical documented with source</td>
<td>☐</td>
</tr>
<tr>
<td>Additional estimated length of stay</td>
<td>☐</td>
</tr>
<tr>
<td>BH criteria including code</td>
<td>☐</td>
</tr>
<tr>
<td>Practitioner notification within time frame, or IPA policy assumes approval</td>
<td>☐</td>
</tr>
<tr>
<td>Appointment for follow-up care documented, within 7 days</td>
<td>☐</td>
</tr>
<tr>
<td>Case was reviewed by PCP or hospitalist in AM and PM every day of stay</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Skilled Nursing - 2 cases, 2 pts each box, total 32**

(If no skilled, choose pre-cert or emergent case)

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial review summary documented within 7 days of admission</td>
<td>☐</td>
</tr>
<tr>
<td>Documented plan of review; for example, “case will be reviewed every 7 days”</td>
<td>☐</td>
</tr>
<tr>
<td>At least one concurrent review</td>
<td>☐</td>
</tr>
<tr>
<td>Clinical documented with source</td>
<td>☐</td>
</tr>
<tr>
<td>Estimated additional length of stay documented</td>
<td>☐</td>
</tr>
<tr>
<td>Documentation of care plan</td>
<td>☐</td>
</tr>
<tr>
<td>All required elements documented: patient name, patient ID, date of review, name of physician(s), diagnosis, procedure, admit date, facility name</td>
<td>☐</td>
</tr>
</tbody>
</table>
Utilization Management Adherence Audit of Participating MG/IPAs
Page 8 of 10

Discharge planning initiated on initial review, potential plan documented

Case was reviewed by PCP or hospitalist in AM and PM every day of stay

Home Health - 2 cases, 2 pts each box, total 20
(If no home health, choose pre-cert or emergent case)

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial review summary documented within 24 hours of receipt</td>
<td>□</td>
</tr>
<tr>
<td>Clinical documented with source</td>
<td>□</td>
</tr>
<tr>
<td>Estimated number of HHC visits documented</td>
<td>□</td>
</tr>
<tr>
<td>Documentation of care plan</td>
<td>□</td>
</tr>
<tr>
<td>All required elements documented: patient name, patient ID, date of review, name of physician(s), diagnosis, procedure, admit date, facility name</td>
<td>□</td>
</tr>
</tbody>
</table>

Case Not Meeting Criteria, Referred to PA - 2 cases, 2 pts each box, total 20
(If not applicable, choose concurrent review case)

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation explains PA’s decision to approve or deny</td>
<td>□</td>
</tr>
<tr>
<td>Date sent to PA</td>
<td>□</td>
</tr>
<tr>
<td>Determination of PA (approval, denial)</td>
<td>□</td>
</tr>
<tr>
<td>Determination within 24 hours of receipt of request</td>
<td>□</td>
</tr>
<tr>
<td>If PA approves continued stay, PA approved additional length of stay documented.</td>
<td>□</td>
</tr>
</tbody>
</table>

Long Stay Case - 2 cases, 2 pts each box, total 20

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission date AND initial date referred to PA documented</td>
<td>□</td>
</tr>
<tr>
<td>Home, family, environment assessment on initial review</td>
<td>□</td>
</tr>
<tr>
<td>Discharge planning initiated on initial review, potential plan documented</td>
<td>□</td>
</tr>
<tr>
<td>Clinical documented with source</td>
<td>□</td>
</tr>
</tbody>
</table>
Referral to PA for weekly review

PA response noted** (not scored)

Medical criteria continued to be met until discharge or weekly PA reviews for extension of length of stay

Informational (one check only)
*Discharged to SNF
OR
Discharged to HHC
OR
Discharged to home
OR
Patient expired
OR
Patient transferred back to inpatient

Case was reviewed by PCP or hospitalist in AM and PM every day of stay

*Not scored
COMPLEX CASE MANAGEMENT:

1 – IPA CAN DEMONSTRATE USE OF THE FOLLOWING DATA TO IDENTIFY POTENTIAL CASE MANAGEMENT CASES:

a) claims data (.5 pt);
b) hospital discharge data (.5 pt);
c) pharmacy data (.5 pt);
d) data collected from the UM process (.5 pt); or
e) D2 report D2 identifying potential CM cases (1 pt).

f) ADDITIONAL SOURCES (health information line, disease management program, discharge planner referral, PCP, PSP, UM referral, patient self-referral) (1 pt if any of these)

2 – IPA PROVIDES AT LEAST 1 COMPLEX CASE MANAGEMENT CASE ON LOG AND A FILE OR DEMONSTRATION OF ANALYSIS FOR POSSIBLE COMPLEX CASE MANAGEMENT. (10 pts)

3 – AT LEAST ONE OF THE COMPLEX CASE MANAGEMENT FILES INCLUDES 80% OF THE FOLLOWING ELEMENTS (12/15 = 80%)

a) evidence based guideline noted;
b) documentation of member or member related contact (includes staff ID, date, time of interaction);
c) date to follow-up with member;
d) initial assessment;
e) life planning activities;
f) evaluation of member’s cultural and linguistic needs;
g) evaluation of available benefits;
h) evaluation of caregiver resources;
i) CM plan for member (short and long term goals);
j) barriers to meeting goals;
k) schedule to follow-up with member;
l) communication documented of member self management plan;
m) assessment of member progress toward goals and overcoming barriers;
n) estimated cost savings or NA; and

o) documentation of CM survey given if case closed.

PLEASE NOTE: If the IPA can demonstrate the use sources a-d or the use of D2 to identify potential complex case management cases, and NO cases are identified as complex, the IPA will be eligible for the 14 points. Documentation must be provided.

Total possible – 14 POINTS
Revised 1/1/10
Policy Name: Utilization Management (UM) Affirmation Statement

Policy Number: Administrative-51
Effective Date: 5/1/00
Revision Date: 2/1/10
Review Date: 2/1/10

Approval Signature:

Senior Medical Director

Vice President–Network Management

Policy:
The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) and all Independent Physician Associations (IPA) are required to distribute an affirmation statement to all staff involved in UM decision making affirming that:

a. UM decisions are based on medical necessity; which includes appropriateness of care and services, and the existence of available benefits;
b. The organization does not specifically reward health plan staff, providers and practitioners or other individuals for issuing denials of coverage, care or service; and
c. Incentive programs are not utilized to encourage decisions that result in under-utilization.
d. There is no conflict of interest between the IPA and it’s UM decision makers.

Purpose/Objectives:
To ensure compliance with the HMOs Utilization Management Plan.

Procedure:
1. IPAs must submit a copy of the UM Affirmation statement which was distributed to the appropriate parties at the time of the UM Plan submission.
2. If there are any additions in IPA UM staff decision-makers throughout the calendar year, a statement must be distributed to them upon employment at the IPA.
3. In addition, the HMO UM Manager annually distributes the policy statement to all BCBSIL management whose staff are involved in UM decision-making. Management is required to distribute to their staff and respond by email to the HMO QI/ UM Project Consultant affirming agreement with the statement.
MEMORANDUM

To: All Practitioners, Providers, Members and Employees

From: IPA Name and IPA #

Date:

RE: UM Affirmation

At (name of IPA) (number of IPA) we affirm that:

1. UM decisions are based on medical necessity, which includes appropriateness of care and services, and the existence of available benefits;

2. The organization does not specifically reward health plan staff, providers and practitioners or other individuals for issuing denials of coverage, care or service; and

3. Incentive programs are not utilized to encourage decisions that result in under-utilization.

4. There is no conflict of interest between the IPA and its UM decision makers.
Policy: Complex Case Management

Policy Name: Complex Case Management
Policy Number: Administrative - 71
Effective Date: 1/1/09
Revision Date: 1/1/10

Approval Signature:

Senior Medical Director
HMO Illinois and Blue Advantage HMO

Vice President–Network Management
Approved QI: 1/6/10 Approved P&P: 12/17/09

Policy:
The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) will assure that members have access to Complex Case Management (CM) based upon medical appropriateness and cost effectiveness.

Purpose:
- To oversee the Independent Practice Association (IPA) who coordinates care and services to members with multiple or complex conditions
- To assist members to access care and services through assistance of an IPA
- To assist members to regain optimal health or improved functional capability through assistance of an IPA

Guidelines: (if applicable)
1. Members and Primary Care Physicians (PCPs) are to be made aware of the ability to refer to complex case management. The IPA will communicate the program through the use of printed materials such as the Welcome Letter, PCP newsletters or a web site.

2. The IPA will review claims data, hospital discharge data, pharmacy data and data collected from the Utilization Management (UM) process (i.e. initial and concurrent review) to identify potential complex cases. Other sources of complex case identification may include health information line referral; disease management program referral; discharge planner referral; PCP, Participating Specialist Provider (PSP), UM referral, or member self-referral. D2Hawkeye will be used to identify potential complex cases for management

Procedure:
1. D2Hawkeye should be utilized quarterly to identify possible complex cases for management. A method of identification should be documented in the IPA UM Plan which includes the following:
   - How potential cases will be identified;
   - Method of documentation for identification of patients not eligible for complex case management;
   - Documentation of why patient was not chosen for complex case management;
   - Method of documentation for information on complex case management cases.
   - The D2 quarterly case review sheet should be submitted to the HMOI nurse liaison by the 10th of the month following the end of the quarter. (See attachment F-quarterly case review sheet)
2. A log of members assisted through the IPA’s complex case management process must be maintained and provided to the HMO upon request. (See attachment A-Complex CM Case Log and attachment B-Directions for Complex CM Log)

3. In addition, the IPA must obtain verbal or written consent and have this documented in the CM file. (See attachment C- CM Consent Form)

4. Oversight of the IPA complex case management process will be performed and scored as part of the case file review portion of the annual UM Adherence Audit. These items are scored and the IPA has the potential to earn 14 points.
   - IPA documents the source used to identify potential CM cases, i.e. claims data, hospital discharge data, pharmacy data, data collected from the UM process or D2 report. All but D2 is valued at a half point. D2 is valued at one point.
   - IPA documents any additional sources used to identify CM cases, i.e., health information line, disease management program, discharge planner referral, PCP, PSP, UM referral, and patient self-referral. Any of these is valued at one point.
   - IPA provides at least one complex case management case on a log and a file or demonstrates the analysis for possible complex CM case. This is valued at ten points. At least one of the complex CM files should include 80% of the elements: (12/15 = 80%) (See attachment D-Complex CM Case Review Audit Tool)

5. IPA Documents that the CM survey was given to the member when the case is closed. (see attachment E-HMO CM Survey).
IPA # and NAME: __________________________________________________________

<table>
<thead>
<tr>
<th>Patient ID/ Name</th>
<th>Date Opened</th>
<th>Identified by (code 1)</th>
<th>Diagnosis</th>
<th>Guidelines used to manage case</th>
<th>Date Closed</th>
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</tbody>
</table>

1. Identification codes:  
A. Claims data  
B. Hospital discharge data  
C. Pharmacy data  
D. Data collected through UM process  
E. D2 Hawkeye report

Reviewed 1/1/10
The case management log does not need to be sent in quarterly. The log will be requested prior to the case management audit. The case management audit cases will be chosen at least two weeks prior to the audit. The HMO log is a sample log, but any IPA log must have all the elements that are requested.

1. Patient ID/ Name – can be any number that enables the IPA to find the patient. Name or initials should also be included.

2. Date Opened - the date the case was opened as a complex case managed case.

3. Identified by – how the case was identified as a complex case management case. Use the sources identified in the HMO UM Plan.

4. Diagnosis – this should be the diagnosis that is associated with the case managed case.

5. Guidelines used – this is not a Yes or No. This column should be completed with the name of the guideline the IPA has adopted.

6. Date closed - this column will remain blank until the patient is no longer being case managed.

Cases should be chosen from this log for audit (AT LEAST 1). Try to choose cases that encompass the different methods of case identification.

Reviewed 1/1/10
Case Management Consent Form

I, ________________________________________, as a member, spouse, or legal guardian of the member agree to participate in the Case Management Program administered by (Insert IPA name) for Blue Cross Blue Shield of Illinois HMO Illinois /BlueAdvantage HMO plan.

I understand that this agreement to participate means:

• I consent to the patient and/or family being contacted by the Case Manager assigned by (Insert IPA name).

• I consent to providers of health care services (hospital staff, physicians, therapist, etc.) being contacted for information about the patient related to the development, implementation and evaluation of a Case Management Program care plan and for the processing of claims for the services provided under the Program.

• I authorize the release of medical information for the purpose stated above.

• I understand that the Case Management Program is voluntary and I may withdraw from the program at any time upon notification to (Insert IPA name) Case Manager or my Primary Care Physician. If I withdraw, my contract benefits, as described in the Benefit Booklet will continue.

• I understand that I should retain a copy of this document for my records and that a photocopy of this form is as valid as the original.

• I have read the above (or the above has been explained to me) and I hereby agree to participate in the Case Management Program and am bound by the contractual provisions of my health insurance contract.

• I understand the information provided or explained to me regarding the Program.

• I understand that if I am dissatisfied with the care or services, for any reason, I can call the (Insert IPA name) Case Manager at (Insert IPA phone number) Monday to Friday, between the hours of 8:00 am and 5:00 pm.

□ I choose NOT to accept Case Management services.

______________________________        _________________________       __________
Signature             Relationship to Patient         Date

If someone else is signing this authorization form on behalf of the member, please provide the following:

*Legal Representative’s name: _______________________________________________________

Relationship to the member: _______________________________________________________

Note: *Please provide written documentation to support your status as a guardian or other legal representative.

Please complete and return in the enclosed stamped self-addressed envelope within (30) calendar days of receipt of letter.

Reviewed 1/1/10
Complex CM Case Review Audit Tool

CASE INFORMATION

IPA # and NAME: _____________________________________________
Document # and name for IPA with complex case management case (CM).

Member Initials (FN, LN)/ ID #: ___________________________________
Document Member first and last initial, unique ID number.

Date case opened: ________________ Date case closed or NA:__________
Document date opened as COMPLEX CM case. Document date when closed or NA if still open in complex case management.

Diagnosis (es): _________________________________________________
Document complex or multiple diagnoses for complex case managed Member.

Goal for Member’s Case:
Check appropriate box for overall goal for this Member.

☐ Regain optimal health
☐ Improved functional capability

COMPLEX CASE IDENTIFICATION PROCESS

IPA must demonstrate each of the methods below and how they are utilized to identify POSSIBLE complex CM cases:

1. Claims data – any type of claims report, re-admission report
2. Hospital discharge data – UM report, hospital report
3. Pharmacy data - # medications, high dollar
4. Data collected from UM process – initial, concurrent, discharge planning
5. D2 Hawkeye report – covers all above, except data collected from the UM process

Optional sources – health information line referral, disease management program referral, discharge planner referral, PCP, PSP, Member self-referral.

1. How was case identified for Complex Case Management (CM)?
Check all that apply ONLY IF demonstrated in written report format, D2, or UM form.

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1. Claims data</td>
<td>.5</td>
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<tr>
<td>☐ 2. Hospital discharge data</td>
<td>.5</td>
</tr>
<tr>
<td>☐ 3. Pharmacy data</td>
<td>.5</td>
</tr>
<tr>
<td>☐ 4. Data collected through UM process</td>
<td>.5</td>
</tr>
<tr>
<td>☐ 5. D2 Hawkeye report or demonstration</td>
<td>2 pts (covers 1, 3)</td>
</tr>
</tbody>
</table>

Extra 1 pt for ANY of the optional sources. Total 4 pts

COMPLEX CASE MANAGEMENT CONSENT

2. Documentation of Member’s verbal or written consent for complex case management.
Must be documentation of Member’s consent to be involved in complex case management. May be verbal consent.
3. Are the following elements documented in file?

1. ☐ Evidence-based clinical guideline
   There is documentation of the name of the guideline and the source.

2. ☐ Member or Member related contact
   Documentation of each Member or Member related contact. Documentation must include: recording of interaction, date, time, ID of individual making contact. Example: ‘SNS, RN 12/4/08 1PM - Spoke with Dorothy Jones at Healthy Home Health Care regarding patients compliance with wound care treatment. Ms Jones will re-inforce the need for the wound care in the AM AND PM. Will check on Member for compliance in one week.’

3. ☐ Date to follow-up with Member
   Documented date for follow-up. Example – ‘Call Member on 12/11/08 – one week follow-up for wound care compliance’.

4. ☐ Initial assessment
   Documentation of current health status, co-morbidities, diagnoses, procedures, history or progression of illness, medications, treatment history, medications, assessment of ability to perform activities of daily living, mental status, and ability to communicate and understand.

5. ☐ Life planning activities
   Documentation of existence of any will, living will, advance directives, power-of-attorney. Document ‘none’, or ‘not applicable’, depending on the case.

6. ☐ Cultural and linguistic needs
   Documentation of language spoken and any cultural preferences, needs that may affect the Member’s care. If no cultural specifics, document ‘none’.

7. ☐ Available benefits
   Documentation of any specific benefit limitations or specifics. Example: ‘Patient has a limitation of 20 home health visits.’ If not applicable, document ‘standard HMO benefits’.

8. ☐ Caregiver resources
   Documentation of any possible caregivers, family members, decision-makers regarding health care.

9. ☐ Individualized care plan
   Documentation of at least one short and long term goal for Member. Goals must be specific with explanation of goal, measurable, expected timeframe, when goal re-measurement will occur. Goals may be used from guidelines, but must be identified or documented.

10. ☐ Barriers
    Documentation of Member barriers to achieve goals. Examples: Member non-compliance, visual impairment, lack of understanding, language barrier, physical impairment, psychological impairment.

11. ☐ Follow-up schedule
    Documentation of a schedule for contact with Member, any referrals, education, self-management support.

Documentation of communication of self-management activities. May include: special diet, chart daily readings, (blood sugar, BP), peak flows, wound care, etc.

13.☐ Assessment of Member progress
   Documentation of Member’s progress toward documented goals, including self-management progress.

14.☐ Estimated inpatient days saved
   Documentation of any estimated inpatient days saved or ‘none’.

15.☐ CM survey given or completed, if case closed
   Documentation of CM survey given, completed, refused or ‘not applicable, if case remains open’.

☐ All 4 sources demonstrated (or D2 and 2 other sources) and NO complex case management cases identified.

OR

☐ 12/15 elements in at least one case documented    Total: 10 pts

Complex case management score - _______ Document point total out of 14

Reviewed 1/1/10
HMO CASE MANAGEMENT SURVEY

IPA NAME: ______________________________________________________________

Dear Member:

You were involved with our case management services from xx/xx/xxxx through xx/xx/xxxx.

In order to assess our services, please take a moment to answer the following questions:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1. Were you satisfied with the case management services provided to you?</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>2. Did the case manager include you in planning your care?</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>3. Did the case manager act in a professional manner?</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>4. Did the case manager provide explanations for treatments and services to help you make informed decisions?</td>
<td>☐</td>
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<td>5. Was the case manager helpful in coordinating your care?</td>
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<tr>
<td>6. Did the case manager prepare you for the end of your case management experience?</td>
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Thank you.

Please return to: ____________________________________________________________

Reviewed 1/1/10
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<th>Individual ID</th>
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<th>CGI</th>
<th>ARI</th>
<th>Age</th>
<th>Gender</th>
<th>CM Status</th>
<th>Not Chosen*</th>
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* Not Chosen Codes (May be Determined by the IPA)
**Method Chosen by IPA

N - No ability to improve
T - Terminally ill
R - Resistant, non-compliant

Reviewed 1/1/10
Policy Name: Inquiry Reporting System Documentation of Benefit Determinations and Quality of Care Inquiries-Complaints

Policy Number: Info Systems 07
Effective Date: 1/1/00
Revision Date: 1/1/08
Review Date: 4/1/10

Approval Signature:

<table>
<thead>
<tr>
<th>Senior Medical Director</th>
<th>Vice President–Network Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO Illinois and BlueAdvantage HMO</td>
<td>Approved QI: 4/1/10 Approved P&amp;P: 3/11/10</td>
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Policy:
Inquiry Reporting System users of the HMOs of Blue Cross and Blue Shield of Illinois will follow standard procedures for the documentation of benefit determinations and quality of care complaints.

DEFINITIONS:
A benefit determination is a written inquiry sent to the HMO requesting interpretation of the HMO member’s medical benefits and services.

Quality of Care issues may be related to clinical care or to clinical services provided by a physician, Independent Physician Association (IPA) or other medical facility. Any inquiry which includes a complaint about the manner in which a member was treated by the physician, the physician’s office, or the IPA should be evaluated for the possibility of a quality of care issue. Quality of care issues may relate to the clinical aspects of care, service, access or interpersonal issues. An allegation of an action related to the process of care, that, if accurate, requires follow-up with the physician or IPA because of the potential that the alleged action could cause harm to a member or could lead to member dissatisfaction should be considered to be potential quality of care inquiries.

An inquiry is a general request for information. An inquiry can be about the range of benefits, policies and procedures, enrollment, claims processing, or a concern that is a conflict of interest between the member, the IPA and the HMO.

A complaint is an expression of dissatisfaction, either oral or written.

PURPOSE/OBJECTIVES:
- To establish a standard procedure and guidelines for entry of benefit determinations and quality of care issues on the Inquiry Reporting System
- To ensure that all requests for benefit determinations are completed in a professional, accurate and precise manner
- To ensure that all quality of care inquiries from HMO members are completed in an accurate and confidential manner
- To ensure that HMO customers are given accurate and appropriate information regarding a benefit determination or quality issue.
PROCEDURE FOR BENEFIT DETERMINATIONS:

1. Requests for benefit determinations received by the HMO will be forwarded to the Customer Assistance Unit (CAU) for a decision.
2. Decisions rendered by the CAU will be formatted in the following manner:
   
   **Facts Section**  (not to be included in the Inquiry Reporting System Notes documentation)
   - Type of benefit determination requested
   - Summary of inquiry and reasons for request, along with information from physician, IPA and/or medical records as to substantiate or refute need for the requested benefit
   - Recommendations from specialist, if applicable
   - When applicable, the Medical Support justification, thought process or rationale for the decision.

   **Decision Section**  (information to be included in the Inquiry Reporting System Notes documentation)
   - HMO benefit determination decision (in benefit or not in benefit)
   - When relevant, additional explanation that should be included in the response to the inquirer. This could include an explanation about portions of the request that are in benefit and other portions that are not
   - The basis for the decision
   - When relevant, determination of financial responsibility if the service is in benefit, if not already clear to all parties.

**Inquiry Reporting System Data Entry**
The Inquiry Reporting System Notes Section for benefit determinations will be divided into two parts.

**Part 1**
*The following information can be communicated to a member contacting the HMO to receive status of their benefit determination:*

- *The HMO’s decision on covering the benefit (in benefit or not in benefit)*

*When quoting benefits, reps must also state that to be eligible for the benefit, the services must be provided by or ordered by the member’s PCP or IPA, and must be medically necessary as determined by the Primary Care Physician (PCP).*

**Part 2 (Confidential to IPA only)**
The information in this section of the Inquiry Reporting System Notes is **confidential to the IPA only**.

- HMO Medical Directors will stipulate in their decision information that should be given only to the member’s IPA.
- HMO staff should only release this information if an administrative representative from the IPA or a physician acting on behalf of the member (PCP or specialist) contacts the HMO for the decision.
NOTE: The member’s IPA should be copied on all benefit determinations requested directly by the member’s PCP or specialist.

This information will include:
The benefit determination
Decision on financial liability
Parameters or conditions of benefit coverage

PROCEDURES FOR QUALITY OF CARE (QOC) COMPLAINTS

CAU staff will investigate QOC issues. Due to the confidentiality and sensitivity of each issue, a separate QOC database will be utilized to enter clinical information.

Inquiry Reporting System Data Entry

The CAU staff enters demographic information and a summary of the member’s complaint into the QOC database and resumes the Inquiry Reporting System entry with:

a. A brief summary of the nature of the complaint (this does NOT include detailed information about the issues involved).

b. Documentation that the inquiry is being investigated.

c. Date the acknowledgement/closure letter was sent to the member.

d. Inquiry Reporting System category, subcategory and Department of Insurance codes. (written inquiries only).

e. The Inquiry Reporting System entry is closed the day the member letter was sent.

NOTE: No detailed information regarding specific medical or alleged quality issues will be entered in the Inquiry Reporting System.
Medical Support
Policy Name: Transition of Medical Care
Policy Number: Medical Support 1
Effective Date: 7/1/00
Revision Date: 8/1/09

POLICY:
The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) provides continuity of care for new and existing members and ensures they are informed of the procedures regarding transition of care (TOC) services when currently undergoing a course of evaluation and/or medical treatment.

GUIDELINES:
Transition of care is applicable under the following circumstances when a member:

- Is displaced due to a specific Primary Care Physician (PCP), Specialist or Independent Physician Association (IPA) termination, or
- Is new to the HMO with an existing condition that is being treated by an out of network physician

Note: The selected IPA is responsible for the care of a new member as of their effective date.

PURPOSE/OBJECTIVES:

- To minimize disruptions of care and avoid adverse clinical outcomes
- To meet appropriate care expectations for both the member and the new IPA
- To comply with Illinois Senate Bill 251, Section 25

PROCEDURE:

1. The HMO notifies new and existing members of the availability of transitional care services based on the following qualifying criteria:
   - Member handbook
   - Member certificate
   - Newsletters
   - Enrollment materials
   - HMO web site
   - HMO welcome letters and
   - Physician departicipation letters
2. Transition of care services are coordinated for new and existing members identified as currently undergoing a course of evaluation and/or medical treatment or have entered into the second or third trimester of pregnancy. Coverage will be provided only for benefits outlined in the member’s certificate.

   a. Examples of medical treatment may include, but are not limited to the following:
      - 2nd and 3rd trimester obstetrics
      - High risk obstetrics (as diagnosed during pregnancy)
      - Chemotherapy and other cancer treatments
      - Physical/Occupational/Speech therapies
      - Allergy treatments
      - Psychotherapy
      - Scheduled invasive procedures (e.g. angioplasty, surgery)
      - Chronic illness (e.g. diabetes, hypertension) which requires frequent monitoring by a physician
      - Home health care
      - Current hospitalizations
      - Skilled nursing care (SNF)
      - Chemical dependency
      - Infertility treatment

3. Members are subject to the following:
   (a) New members must request the option of transitional services in writing, within 15 business days after their eligibility effective date.
   (b) Existing members must request the option of transitional services in writing, within 30 business days after receiving notification of the termination of the physician or IPA.

4. Services can only be requested if the physician is not a member of the HMO provider network, but is within the health care plan’s service area.

   Note: If the provider is in the HMO network, the member has access via selection of the appropriate IPA that contracts with the provider and therefore transitional services are not applicable.

   HMO network physicians closed to new patients must accept a newly enrolled HMO patient as their patient if the member’s course of evaluation and/or medical treatment was started with this physician.

4. Upon receipt of a transition of care request, the Customer Assistance Unit (CAU) sends the member a transition of care form for completion with the following information:

   - Member name
   - Work/home phone number
   - Group/ID number
   - Chosen IPA site
Transition of Medical Care
Page 3 of 3

- Chosen PCP name, phone, fax and address
- Current treating physician
- Clinical diagnosis
- Presenting clinical condition
- Reason for transition of care request
- Expected effective date with the HMO or new IPA (if applicable)

5. Upon receipt of the transition of care information, the CAU forwards the member’s request to Provider Contracting. The provider is sent a letter via facsimile requesting the clinical treatment plan related to the patient and agreement to the following:

- reimbursement from the HMO at specified rates
- adherence to the HMO’s quality assurance requirements and
- the HMO’s policies and procedures

6. The provider must return the signed letter within five business days from receipt.

7. If the provider does not accept the contract or does not respond within the five business day timeframe, Provider Contracting notifies the CAU via email and updates the information on the TOC database.

8. Upon receipt of the signed letter and treatment plan, Provider Contracting will update the appropriate information on the designated database and notify the CAU via email.

   a. The CAU will email the Rockford Claims Supervisor requesting an alert on the claims processing and Inquiry Tracking System (ITS). A copy of the letter and treatment plan will be scanned into the original inquiry as an insert.

   b. The member is sent a confirmation of treatment authorization with applicable guidelines (clinical treatment approval, 90 calendar day maximum, etc.) within 15 business days of receipt of the original request and the ITS is updated.

   c. The member’s selected IPA, if known, is sent a copy of the member confirmation letter.

10. The member is sent a denial letter within 15 business days of the original request and informed of appeal rights and the ITS updated. The CAU will scan a copy of the letter into the original inquiry as an insert.
AMPLE 1 – TRANSITION OF CARE ACKNOWLEDGEMENT AND REQUEST FOR INFORMATION (EXISTING MEMBER)

DATE: ____________________

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re:   Patient Name
      Group and Member ID #
      Transition of Care request

Dear _________________:

The HMOs of Blue Cross and Blue Shield of Illinois are in receipt of your letter requesting transition of care services. We cannot process your request without additional information.

Please submit the following:

♦ Your work and home telephone number
♦ Name, address, phone and fax number of the physician you wish to continue to see
♦ The condition for which you are currently seeing the physician
♦ The type and frequency of services you expect to need during the transitional period

Once we receive this information, we will process your request. Please keep in mind this information must be submitted within 30 days of the receipt of the original letter notifying you that your current Independent Physicians Association (IPA) will no longer be in our network.

Your letter should be directed to the attention of:

Blue Cross and Blue Shield of Illinois
Health Care Management
Customer Assistance Unit
300 East Randolph, 27th floor
Chicago, Illinois 60601

Please contact us at 1-800-892-2803 if you require assistance selecting a new IPA

Sincerely,

____________________
Health Services Assistant
Health Care Management

HMO Illinois and BlueAdvantage HMO
SAMPLE 1A - TRANSITION OF CARE ACKNOWLEDGEMENT AND REQUEST FOR INFORMATION (NEW MEMBER)

DATE: _________________

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re: Patient Name
Group and Member ID #
Transition of Care request

Dear _________________:

The HMOs of Blue Cross and Blue Shield of Illinois are in receipt of your letter requesting transition of care services. We cannot process your request without additional information.

Please submit the following:

♦ Name, address, phone and fax number of the physician you wish to continue to see
♦ The condition for which you are currently seeing the physician
♦ The type and frequency of services you expect to need in the transitional period
♦ Work and/or home phone number
♦ Expected effective date with the HMO
♦ Independent Physicians Association (IPA) selected (if applicable)

Once we receive this information, we will process your request. Your letter should be directed to my attention at:

Blue Cross and Blue Shield of Illinois
Health Care Management
Customer Assistance Unit
300 East Randolph, 27th floor
Chicago, Illinois 60601

Please contact us at 1-800-892-2803 if you require assistance selecting a new IPA.

Sincerely,

____________________
Health Services Assistant
Health Care Management
SAMPLE 2- APPROVED TRANSITION OF CARE (MEMBER)
(this letter would be sent to the member once the agreement and treatment plan is received)

DATE

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re: PATIENT NAME CASE #__________________
GROUP AND MEMBER ID

Dear PATIENT NAME:

Please allow this letter to serve as a response to your request for transitional care. You will be allowed to continue to see DOCTOR NAME from ____ to______ for (REASON/DX).

Our letter can serve as the referral for these services. Also, you will be required to pay any co-payments or deductibles, if applicable, for any of the transition of care services. Additional follow-up care after the above mentioned date needs to be coordinated with your new Primary Care Physician (PCP) and Independent Physicians Association (IPA). No additional bills from DOCTOR NAME will be paid after the above date.

If you receive any claims for these services, please send them with a copy of this letter to:

Blue Cross and Blue Shield of Illinois
Health Care Management
Customer Assistance Unit
300 East Randolph, 27th floor
Chicago, Illinois 60601

Please remember as of DATE, you will need to select a new IPA and PCP for all of your other health care needs. (or use the following: Please remember as of DATE, you will need to use your selected IPA or PCP for these services.) Please provide a copy of this letter to your selected IPA for their records if they have not been copied. This will help them to coordinate your care after the transition period ends.

If you should have any questions, please call me at (312) 653-6600.

Sincerely,

____________________
Health Services Assistant
Health Care Management

cc: IPA (if available)

HMO Illinois and BlueAdvantage HMO
SAMPLE 3 –TRANSITION OF CARE LETTER OF AGREEMENT (DOCTOR)

«DateofLetter»

«PhysicianName»
«PhysicianAddress»
«PhysCityStateZip»

Re: «PatientName»
«PatientGroupID»

Dear «PhysicianName»:

We are in receipt of a letter from the above member for continuation of care after «TOCDate». Consider this letter as a contractual agreement between «PhysicianName» and Blue Cross and Blue Shield of Illinois, that you are agreeing to coordinate transitional care for this member. Please sign below and provide us with a copy of the patient’s diagnosis and current treatment plan within the next five business days. Please be advised that no treatment plan will be approved beyond a 90 day period except for 2nd and 3rd trimester pregnancies which will be approved through the postpartum period. If we do not hear from you within this five day period, we will notify the patient that their request has been denied.

The claims for services provided after «TOCDate» will be adjudicated using the current year Medicare RBRVS Locality 16 fee schedule. **Applicable co-payments and/or deductibles will apply to all transition of care services.** Signing this letter of agreement indicates you are accepting the Medicare reimbursement as payment in full and you will not balance bill the patient. You are also agreeing to provide, **upon request**, any applicable medical records pertaining to this patient. Please sign below, date and fax a copy of this letter and the treatment plan to my attention at (312) 861-0149.

MD Signature: ______________________________

Date: ______________________________

Effective «TOCDate» the member must coordinate all other services not included in the treatment plan with their new IPA and Primary Care Physician. **Any services that are not related to this diagnosis and treatment plan will not be paid.** If this member requires additional services, **the member** should be referred to the new IPA. If it becomes necessary to further refer this member for additional services related to the diagnosis on the treatment plan, please contact me for authorization at 312-xxx-xxxx. Referred services that are related to the diagnosis on the treatment plan will not be approved without prior authorization.

All claims for services should be sent with a copy of this letter to:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

Thank you very much for your cooperation with this patient. If you have any questions, please feel free to call me at (312) xxx-xxxx, fax number (312) xxx-xxxx.

Sincerely,

Network Development Person’s Name
Network Development Person’s Title, Network Development

HMO Illinois and BlueAdvantage HMO
SAMPLE 4- DENIAL OF TRANSITION OF CARE (MEMBER)
(this letter would be sent to the member if no agreement or plan of treatment is received after 5 days)

DATE

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re: PATIENT NAME
GROUP AND ID NUMBER
Transition of Care Services for: DX OR SERVICES

Dear PATIENT NAME:

Please accept this letter as formal notification that your transition of care request has been denied by the HMOs of Blue Cross and Blue Shield of Illinois.

A letter was sent to DOCTOR NAME on DATE, requesting that he/she sign our letter of agreement and provide us with the treatment plan, however no response was received. Therefore, since DOCTOR NAME is not in our network we will not pursue this matter further. Please contact your selected Independent Physicians Association (IPA) to arrange for any care and/or treatment you require.

As a reminder, any services provided by DOCTOR NAME after DATE (new IPA effective date) are considered out-of-network and are not eligible for payment.

If you should have any questions you can contact us by either calling 800-892-2803 or writing to Blue Cross and Blue Shield of Illinois, Health Care Management, Customer Assistance Unit, 300 E. Randolph, 27th floor, Chicago, Illinois, 60601. If you wish to appeal this decision, a first level appeal can be requested either orally or in writing by you, a practitioner or other representative acting on your behalf.

If the HMO Level 1 appeal is not resolved in your favor, the case will be forwarded for a second level appeal. The HMO Level II Appeal will be reviewed and a written decision provided within 30 working days. If the HMO Level II Appeal is denied you can:

• contact the Illinois Department of Insurance or
• contact the HMO to request a review by an Independent Review Organization (IRO) for all clinical appeals.

Our goal is to respond timely to all inquiries, complaints and appeals by notifying you of the final disposition and further review procedures if applicable. You may also reference your “Certificate of Health Care Benefits” for procedures related to filing claims, inquiries, complaints and appeals.

Sincerely,

Health Services Assistant
Health Care Management

HMO Illinois and BlueAdvantage HMO
SAMPLE 4A- DENIAL OF TRANSITION OF CARE (MEMBER)
(this letter would be sent to the member if no agreement was signed by Doctor)

DATE

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re: PATIENT NAME
GROUP AND ID NUMBER
Transition of Care Services for: DX OR SERVICES

Dear PATIENT NAME:

Please accept this letter as formal notification that your transition of care request has been denied by the HMOs of Blue Cross and Blue Shield of Illinois.

A letter was sent to DOCTOR NAME on DATE, requesting that he/she sign our letter of agreement and provide us with the treatment plan. DOCTOR NAME, has refused to sign our letter of agreement. Therefore, since the doctor is not in our network, we have no recourse to pursue this matter further. Please contact your selected Independent Physicians Association (IPA) to arrange for your care and/or treatment.

As a reminder, any services provided by DOCTOR NAME after DATE (new IPA effective date) are considered out-of-network and are not eligible for payment.

If you should have any questions you can contact us by either calling 800-892-2803 or writing to Blue Cross and Blue Shield of Illinois, Health Care Management, Customer Assistance Unit, 300 E. Randolph, 27th floor, Chicago, Illinois, 60601. If you wish to appeal this decision, a first level appeal can be requested either orally or in writing by you, a practitioner or other representative acting on your behalf.

If the HMO Level 1 appeal is not resolved in your favor, the case will be forwarded for a second level appeal. The HMO Level II Appeal will be reviewed and a written decision provided within 30 working days. If the HMO Level II Appeal is denied you can:

- contact the Illinois Department of Insurance or
- contact the HMO to request a review by an Independent Review Organization (IRO) for all clinical appeals.

Our goal is to respond timely to all inquiries, complaints and appeals by notifying you of the final disposition and further review procedures if applicable. You may also reference your “Certificate of Health Care Benefits” for procedures related to filing claims, inquiries, complaints and appeals.

Sincerely,

________________________
Health Services Assistant
Health Care Management
SAMPLE 5- DENIAL OF TRANSITION OF CARE (MEMBER)
(this letter would be sent to the member if request was received after either the 15 or 30 days allowed.)

DATE

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE
Re: PATIENT NAME
GROUP AND ID NUMBER
Transition of Care Services for: _DX OR SERVICES____

Dear PATIENT NAME:

Please accept this letter as formal notification that your transition of care request has been denied by the HMOs of Blue Cross and Blue Shield of Illinois because it was not received within the 15 OR 30 day timeframe allowed for (A NEW MEMBER OR AN EXISTING MEMBER).

As a reminder, any services provided by DOCTOR NAME after DATE (new Independent Physicians Association (IPA) effective date) are considered out-of-network and are not eligible for payment. Please contact your selected IPA to arrange for your care and/or treatment.

If you should have any questions you can contact us by either calling 800-892-2803 or writing to Blue Cross and Blue Shield of Illinois, Health Care Management, Customer Assistance Unit, 300 E. Randolph, 27th floor, Chicago, Illinois, 60601. If you wish to appeal this decision, a first level appeal can be requested either orally or in writing by you, a practitioner or other representative acting on your behalf.

If the HMO Level 1 appeal is not resolved in your favor, the case will be forwarded for a second level appeal. The HMO Level II Appeal will be reviewed and a written decision provided within 30 working days. If the HMO Level II Appeal is denied you can:

- contact the Illinois Department of Insurance or
- contact the HMO to request a review by an Independent Review Organization (IRO) for all clinical appeals.

Our goal is to respond timely to all inquiries, complaints and appeals by notifying you of the final disposition and further review procedures if applicable. You may also reference your “Certificate of Health Care Benefits” for procedures related to filing claims, inquiries, complaints and appeals.

Sincerely,

________________________
Health Services Assistant
Health Care Management

HMO Illinois and BlueAdvantage HMO
SAMPLE 6- DENIAL OF TRANSITION OF CARE (MEMBER)
(this letter would be sent to the member if request was not for services that would qualify for transition services)

DATE

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re: PATIENT NAME
GROUP AND ID NUMBER
Transition of Care Services for: DX OR SERVICES

Dear PATIENT NAME:

Please accept this letter as formal notification that your transition of care request has been denied by the HMOs of Blue Cross and Blue Shield of Illinois because your diagnosis and/or treatment plan does not qualify you for transition of care services.

As a reminder, any services provided by DOCTOR NAME after DATE (new Independent Physicians (IPA) effective date) are considered out-of-network and are not eligible for payment. Please contact your assigned IPA to arrange for continuation of this care and/or treatment.

If you should have any questions you can contact us by either calling 800-892-2803 or writing to Blue Cross and Blue Shield of Illinois, Health Care Management, Customer Assistance Unit, 300 E. Randolph, 27th floor, Chicago, Illinois, 60601. If you wish to appeal this decision, a first level appeal can be requested either orally or in writing by you, a practitioner or other representative acting on your behalf.

If the HMO Level 1 appeal is not resolved in your favor, the case will be forwarded for a second level appeal. The HMO Level II Appeal will be reviewed and a written decision provided within 30 working days. If the HMO Level II Appeal is denied you can:

- contact the Illinois Department of Insurance or
- contact the HMO to request a review by an Independent Review Organization (IRO) for all clinical appeals.

Our goal is to respond timely to all inquiries, complaints and appeals by notifying you of the final disposition and further review procedures if applicable. You may also reference your “Certificate of Health Care Benefits” for procedures related to filing claims, inquiries, complaints and appeals.

Sincerely,

Health Services Assistant
Health Care Management

HMO Illinois and BlueAdvantage HMO
SAMPLE 7- DENIAL OF TRANSITION OF CARE  (PROSPECTIVE MEMBER)

(this letter would be sent to a prospective member requesting transition services or a member that has no confirmation of membership)

DATE

SUBSCRIBER AND/OR PATIENT NAME
ADDRESS
CITY/STATE

Re:  PATIENT NAME
GROUP AND MEMBER ID
Transition of Care Services for:  _DX OR SERVICES____

Dear PATIENT NAME:

This letter is in response to your inquiry received in our office on Date received requesting transition of care services.

This is to advise you that since you have no verification of membership, we are unable to move forward with your request for transition of care. Once you have been assigned a group and identification number or have received confirmation of your enrollment with the HMO, you will need to provide our office with this information. At that time we can process your request for transition of care.

Should you have any questions, please call me at (312) 653-6600.

Sincerely,

________________________
Health Services Assistant
Health Care Management

HMO Illinois and BlueAdvantage HMO
Transition of Care (TOC) Script

1. **Is a prospective member eligible for TOC services?**

   Prospective members are not eligible for TOC services. The person **must** be a member. If a person completes an HMO Illinois/BlueAdvantage application, but is not in the system, **they will** need to submit a copy of the application or a Voice Response Unit (VRU) confirmation (if this is the employer’s mode of enrollment) along with their TOC request.

2. **If my doctor is in the HMO Network, do I need to request TOC services?**

   **No.** The member has access to network physicians via Primary Care Physician (PCP) selection of the appropriate *Independent Physicians Association (IPA).*

3. **If I’m a BlueAdvantage member and my physician is not in the BlueAdvantage network, however he is in the HMO network, do I need to request TOC services?**

   **Yes.** The HMO networks are not interchangeable. Therefore, transition of care services must be requested.

4. **If a physician does not accept HMO reimbursement for TOC services, does the member have the right to appeal?**

   **Yes.** The standard appeal process applies.

5. **Are there circumstances by which the HMO will approve TOC services beyond the 90 day timeframe?**

   **Yes.** Only for 2\textsuperscript{nd} and 3\textsuperscript{rd} trimester pregnancy TOC cases. These cases are automatically covered through the postpartum period.

6. **Can a member request TOC services for multiple conditions from different physicians?**

   **Yes.** The member can have more than one ongoing course of treatment which could require different physicians.
- STOP -

YOU MUST BE ENROLLED BEFORE COMPLETING THIS FORM

HMO TRANSITION OF CARE FORM

Patient Name: ____________________________________________________________

Group/ID Number: _______________________________________________________

Home Phone #: ___________________________________ Work Phone #: __________

PHYSICIAN REQUESTED FOR THE TRANSITION PERIOD

First Name ___________________________________ Last Name ___________________

Address ________________________________________________________________

Phone #: ______________________________ Fax #: ____________________________

CLINICAL DIAGNOSIS

________________________________________________________________________

________________________________________________________________________

PRESENTING CLINICAL CONDITION

________________________________________________________________________

REASON FOR TRANSITION OF CARE REQUEST

________________________________________________________________________

IF YOU ARE A NEW MEMBER, WHAT IS YOUR EFFECTIVE DATE WITH THE HMO?

Chosen PCP: ___________________________ Chosen WPHCP: __________________

Chosen IPA: ___________________________ Chosen WPHCP IPA: ________________

Attention: Existing HMO Member
Transition of Care forms must be received by the HMOs of Blue Cross and Blue Shield within 30 business days after receiving notification of the termination of your physician or IPA.

Attention: New HMO Member
Transition of Care forms must be received by the HMOs of Blue Cross and Blue Shield within 15 business days after your eligibility effective date. If you are submitting this form prior to your effective date, please include copy of signed application and/or confirmation of enrollment with the HMO.

Transition of Care Forms may be faxed to the Customer Assistance Unit at 312-938-7859 or mailed to:

HMOs of Blue Cross and Blue Shield of Illinois
Attention: CAU Department
300 E. Randolph, 27th Floor Chicago, IL 60601

Reviewed 8/1/09
Quality Improvement
Policy:

The Managed Care Products of Blue Cross and Blue Shield of Illinois (BCBSIL) onsite audit staff will adhere to Quality Site Visit Standards when conducting quality onsite site visit audits for participating HMO Illinois and BlueAdvantage HMO Primary Care Physicians (PCPs) and high volume Behavioral Health Practitioners. Quality site visits are performed for all HMO PCPs every two years to comply with Illinois Department of Public Health requirements. A site visit review will be performed when the HMO receives at least two member complaints within 12 months for a network practitioner. If the complaint indicates a potential patient safety issue, a site visit will be done after one complaint. The site visit will be completed within 60 days of receipt of the complaint in the quality onsite review department.

High volume Behavioral Health Practitioners (those practitioners who see greater than 25 unique patients per year) are determined on an annual basis through IPA reporting and/or analysis of encounter data of unique patient visits for each Behavioral Health Practitioner.

Purpose:

To audit managed care practitioners against established Quality Site Visit standards including information related to the following:

- Accessibility;
- Office site;
- Emergency Preparedness;
- Medical Record Review; and
- Preventive Services. (Not audited for Behavioral Health)

Procedure:

A. BCBSIL auditors will schedule a visit with the practitioner office, provide a copy of the onsite standards by which the practitioner will be evaluated and conduct an inspection of the office site which includes, but is not limited to:

1. Member’s ability to access health care.

2. Inspection of the office site including a patient examination room to evaluate compliance with Standards.

3. Medical record review of at least five medical records per PCP to evaluate compliance with medical record and preventive care standards.
I. ACCESSIBILITY STANDARDS

Purpose:

To evaluate whether members have appropriate access to medical services.

Procedure:

A. BCBSIL has specific service expectations for participating Managed Care Practitioners. They are as follows:

1. Physician response to an emergency call within 30 minutes.
2. Schedule urgent visits within 24 hours.
3. Schedule routine appointments within 10 business days or two weeks of request, whichever is sooner.
4. Schedule extended visits (i.e., comprehensive exam, preventive care appointment, etc.) within four weeks of request.
5. Arrange for an answering system after office hours that members can access through the usual office protocol:
   ⇒ Response to emergency phone calls should be within 30 minutes.

II. SITE REVIEW STANDARDS

Purpose:

To assess whether members have appropriate access to healthcare services in a clean and safe environment.

Procedure:

1. Environment:
   − The site should be clean and well organized to accommodate patient services.
   − Restrooms, doorways and hallways should be easily accessible.
   − The waiting room should have adequate seating for the volume of patients.
   − There should be an adequate number of exam rooms based on the number of practitioners.
   − The site should be accessible to those with disabilities. Please note: The building must be compliant with ADA (American Disabilities Act) guidelines. If any ADA guideline is not met, the practitioner will have two years from the date of the site review to become compliant with the ADA guideline. Continued non-compliance with the guideline(s) may result in departicipation from the HMO network(s).
     - There should be at least one entrance to the office that is accessible to those with impaired mobility or those in a wheel chair.
     - There should be at least one exam room that can be accessed by doorways and hallways that are at least 36 inches wide.
     - There should be at least one restroom that can be accessed by doorways and hallways that are at least 36 inches wide.
2. **Safety Measures:**
   - The Practitioner and his/her staff should follow the Centers for Disease Control and Prevention [Universal Precautions](https://www.cdc.gov) guidelines when providing patient care.
   - Bio-hazardous waste must be discarded according to OSHA guidelines.
   - Sharp disposal containers must be available.
   - Fire Extinguisher must be accessible.

3. **Lab Specimens and Medication Maintenance/Storage:**
   - Sample drugs, over-the-counter medications, prescription drugs, and vaccines should be stored in restricted patient areas.*
   - Controlled substances, if present, should be stored in a locked area along with an inventory list.
   - **Offices should have policies and procedures for checking medications for expiration dates and for discarding expired medications.**
   - All medications should be routinely monitored for expiration dates.
   - **Opened medications should be labeled with the date the item was opened.**
   - Medication and/or lab refrigerators should be free of food. (Medications and lab specimens may be stored in the same refrigerator if stored in separate areas).

4. **Medical Supply and Equipment Maintenance/Storage:**
   - Sharps should be stored in restricted patient areas.*
   - Prescription pads should be stored in restricted patient areas.*
   - **Medical equipment should be monitored for sterilization and a maintenance log should be maintained for equipment.**
   - **Sterile supplies should be monitored for expiration dates.**

5. **Medical Record System:**
   - Medical records should be handled in a confidential manner. The office must have a written policy that addresses Health Insurance Portability and Accountability Act (HIPAA) requirements regarding Protected Health Information (PHI).
   - **The office must have a confidentiality of medical records policy and follow the policy.**
   - The Practitioner should have a written policy/procedure detailing how medical record information is to be released.

6. **Patient Education:**
   - Educational materials or literature regarding at least three preventive services and at least two medical conditions relevant to the practitioner’s practice must be available for patient use. Examples of preventive materials might be: information about breast self-exam, mammography, Pap smears, pediatric immunizations, coronary risk reduction, or prostate screening. Materials about conditions relevant to the practitioner’s practice could cover topics such as asthma management, diabetes management, management of abnormal Pap smears, and pregnancy care.

---

*Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.

**Indicates non-scored item.
III. EMERGENCY PREPAREDNESS

Procedure:

1. Emergency Preparedness

   --- The Practitioner should have a written procedure on how to handle a medical emergency for members accessing care at his/her facility. This procedure must be posted in a prominent location or easily accessible through a central file/manual.

   --- At least one staff member who has Cardiopulmonary Resuscitation (CPR) Certification should be available during patient care hours. This certification must be kept current and documentation of certification must be available for verification upon request. A valid CPR card will be accepted via fax within one week of the onsite visit.

IV. MEDICAL RECORD REVIEW

Purpose:

BCBSIL requires member medical records to be maintained in a manner that is current, detailed, organized, and easily accessible. All patient data should be filed in the medical record, (i.e., lab, x-ray, consultation notes, etc.) Documentation of a member’s care should facilitate communication, coordination and continuity of care and promote efficiency and effectiveness of treatment.

Procedure:

Please note: A history form can include many of the required documentation items. This form can be completed by the patient, office staff or physician. The physician should review the form for completeness, sign and date the form. Blank areas on the form will be scored as non-compliant. The form must be updated at least every three years for adults and at least every five years for the pediatric patient. Preventive care services must be performed according to the dates required per element.

1. Past Medical History: There should be documentation of a past medical history obtained by the third visit or within one year of the first visit, whichever comes first. The past medical history should be updated at least every three years for adults and every five years for pediatric patients.

2. Family History: There should be documentation of a family medical history obtained by the third visit or within one year of the first visit, whichever comes first. The family medical history should be updated at least every three years for adults and every five years for pediatric patients.

3. Social History: There should be documentation of a social history (including, but not limited to, information about family and occupation, and assessment of tobacco, alcohol and illicit substance use) obtained by the third visit or within one year of the first visit, whichever comes first. For pediatric patients, the developmental milestones may be included. The social history should be updated at least every three years for adults and every five years for pediatric patients.
4. **Physical Activity Assessment/ Counseling:** There should be documentation of assessment and/or counseling regarding physical activity obtained by the third visit or within one year of the first visit, whichever comes first. The physical activity assessment/counseling should be updated at least every two years (ages 18 and above) or every one year (ages 3-17).

5. **Body Mass Index (BMI):** There should be documentation of the patient’s BMI (BMI percentile for children) by the third visit or within one year of first visit, whichever comes first. The BMI should be updated every two years for ages 18-74 and the BMI percentile every year for children ages 2-17.

6. **Weight Management Counseling:** There should be documentation of education regarding weight management for adults with a BMI over 30 and children with a BMI percentile over 85% by the third visit or within one year of first visit, whichever comes first.

7. **Nutrition Counseling for Children:** There should be documentation of nutrition counseling every year for patients ages 2-17 years.

8. **Adult Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years. *In 2010, annual evaluation of alcohol use will be audited, but not scored.*

9. **Utilization of an Alcohol Assessment Tool for an Adult:** There should be documentation of the use of an alcohol assessment tool if the patient answers “yes” to alcohol use.

10. **Adolescent Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using alcohol, it should be noted. The history of alcohol use should be updated every three years. *In 2010, annual evaluation of alcohol use will be audited and not scored.*

11. **Utilization of an Alcohol Assessment Tool for an Adolescent:** There should be documentation of the use of an alcohol assessment tool if the patient answers “yes” to alcohol use.

12. **Adult Inappropriate/Illicit Substance Use:** There should be documentation regarding inappropriate/illicit substance use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using illicit substances, it should be noted. The history of substance use should be updated every three years.

13. **Recommendation for Adult Inappropriate/Illlicit Substance Use Treatment:** Instructions and/or education about recommendation for treatment should be provided to members who are identified as using inappropriate/illicit substances.

14. **Adolescent Inappropriate/Illlicit Substance Use:** There should be documentation regarding inappropriate/illicit substance use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the member is currently...
Quality Site Visit Standards
Page 6 of 18

using illicit substances, it should be noted. The history of substance use should be updated at least every three years. In 2010, annual update of use will be audited and not scored. **

15. Recommendation for Adolescent Inappropriate/Illlicit Substance Use Treatment: Instructions and/or education about recommendation for treatment should be provided to adolescents age 12-17 who are identified as using inappropriate/ illicit substances.**

16. Smoking History for Adults: There should be documentation of a smoking history obtained by the third visit or within one year of the first visit, whichever comes first, on adults age 18 and over. If the member is currently smoking, it should be noted. The smoking history should be updated every two years. If the patient has not smoked for more than five years, this should be documented then smoking history does not need to be noted every two years.

17. Recommendation for Smoking Cessation for Adults: Instructions and/or education about smoking cessation should be provided to members age 18 and over who are identified as smokers. If the patient smokes, update the smoking history at least every two years and provide smoking cessation advice at least annually.

18. Smoking History for Adolescents: There should be documentation of a smoking history obtained by the third visit or within one year of first visit, whichever comes first, on adolescents age 12-17. The smoking history should be updated at least every two years.**

19. Recommendation for Smoking Cessation for Adolescents: Instructions and/or education about smoking cessation should be provided to adolescents age 12-17 who are identified as smokers. If the patient smokes, update the smoking history at least every two years and provide smoking cessation advice at least annually. **

20. Coordination between Medical and Behavioral Health Care: If the member is seeing a Behavioral Health Practitioner, there should be documentation of communication between the Behavioral Health Practitioner and the referring physician. Documentation should include, but not be limited to, follow-up regarding coexisting medical and behavioral health disorders and medication management. If the member refuses to allow such communication, this should be documented.

21. Immunization Documentation: Documentation of immunizations administered by the office staff should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review.

22. Chief Complaint/History Relevant to Problem: Subjective information identifying why the patient is seeking medical attention should be documented. The description should include pertinent history, symptoms, and other related information.

23. Physical Examination: A pertinent physical examination, relevant to the problem, should be documented.
24. Vital Signs: Vital signs, consistent with the patient’s chief complaint, relevant problem and/or diagnosis, should be documented.

25. Diagnosis/Assessment: A diagnosis and/or assessment, consistent with the findings, should be documented.

26. Treatment Plan/Plan of Care: A plan of diagnosis (lab testing, x-rays, etc.) and management (medication dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented. If an abnormal lab or x-ray finding is identified in the medical record, the plan of care should address these findings.**

Education relevant to the patient’s conditions or treatment must be documented at least annually.**

27. Previous Problems: Unresolved problems and/or chronic problems from previous office visits should be addressed in subsequent visits.

28. Continuity of Care, Follow-Up Care, Calls or Visits: Follow-up care, communication of test results, calls/visits should be documented to indicate continuity of care.

29. Consultations: Documentation of response/feedback from a referral for consultation to a specialist should be present in the record and should be signed/initialed by the practitioner and/or there should be a notation in the progress notes indicating that the feedback from the specialist has been reviewed.

30. Chart Organization: The Practitioner should maintain a uniform medical record system of clinical recording and reporting with respect to services which includes separate sections for progress notes and the results of diagnostic tests.

31. Biographical Information: Each medical record should contain the patient’s address, employer, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant. Biographical information should be updated at least every three years.

32. Patient Identifiers: Patient identifiers should appear on each page of the medical record (patient name or unique ID number).

33. Date and Signature: All entries are to be dated and signed/initialed by the author. Author identification may be a handwritten signature, unique electronic identifier or initials.

34. Legibility: All entries should be legible.

35. Allergy Status: Medication allergies should be noted in a prominent location in the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently and consistently noted. Allergies to environmental allergens, food, pets, etc., should also be noted. Allergy histories should be obtained every three years for adults and every five years for pediatric patients. Allergies should be updated at least annually, but will not be scored in 2010.**
36. **Problem List:** There should be a current problem list, either kept separately or within each practitioner progress note, which includes significant illnesses and medical conditions. A health maintenance record should be present if there are no documented relevant problems. The problem list must be inclusive of all problems whether a separate list or within each practitioner’s note.

37. **Medication List:** There should be a current medication list, either kept separately or within each practitioner progress note. The medication list must be inclusive of all medications, whether a separate list or within each Practitioner progress note, and include prescription initial or refill dates.

38. **Lab/X-Ray/Diagnostic Results:** The results of all labs, x-rays and diagnostic testing, should be posted in the chart. The reports should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that they have been reviewed.

** This standard will not be included in the scoring results.

V. **PREVENTIVE SERVICES**

**Purpose:**
To ensure that members have appropriate access to preventive care services.

**Procedure:**

BCBSIL has specific Preventive Health Care Guidelines based on national recommendations. Practitioners should provide services in accordance with these guidelines. The offer of services and the subsequent results or the member’s refusal to accept services should be documented in the member’s medical record. If the service was provided by another practitioner (example: OB/GYN), document in the medical record that the service was provided, with the date and the results. Preventive care services should be provided by the third visit or within one year of the first visit, whichever comes first. The date of service and results or findings should be documented in the medical record. The medical records will be reviewed for performance of the following preventive care services:

A. **Adult Female:**

1. **Non-fasting cholesterol** should be performed every five years on members over age 45. The medical record should document the date and results or findings. Only medical records for members age 46 and over will be audited for this measure.

2. **Pap Smear(s) (Age 21-69)** should be performed approximately three years after becoming sexually active, but no later than age 21. Screen every year with conventional PAP tests or every two years using liquid-based Pap tests. At or after age 30, women who have had three consecutive normal tests may get screened every two to three years with cervical cytology or every three years with an HPV DNA test plus cervical cytology. Women 70 years of age and older who have had three or more normal Pap tests and no abnormal Pap tests in the last ten years may choose to stop cervical cancer screening. Women who have had a total hysterectomy may choose to stop screening. The medical record should document the date of Pap smear service and results or findings. Only medical records for members age 22-69 will be audited for this measure.
3. **Mammography** should be performed every one to two years for members age 40 and over, and date of service and results or findings, should be documented in the medical record. Members who have had bilateral mastectomies should be excluded from screening, and should have the dated history of bilateral mastectomies documented in the medical record. Medical records for members age 42-69 will be audited for this measure.

4. **Colorectal cancer screening** should be performed for members age 50-75, by means of ONE of the following screening options:
   - Fecal occult blood test within the past 12 months (FOBT performed during a physical exam on a specimen obtained from a digital rectal exam does not count, because it is not specific or comprehensive enough to screen for colorectal cancer.)
   - Flexible sigmoidoscopy within the past five years
   - Fecal occult blood annually plus flexible sigmoidoscopy within the past five years
   - Colonoscopy within the past 10 years
   Only medical records for members age 52-75 will be audited for this measure. The chart must include the date, type of test and results.

5. **Influenza vaccinations** should be administered annually to members at high risk for complications from influenza and to those members age 65 and over. (The medical records audited will include adult members with asthma, diabetes, and cardiovascular disease (CVD) and members age 65 and over). Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name of the person administering the vaccine. If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review. **Ages 50-65 will be audited.**

6. **Bone Density Testing for Osteoporosis should be performed at least once for women after age 65.**

**B. Adult Male:**

1. **Non-fasting cholesterol** should be performed every five years on members over the age of 35. The medical record should document the date and results or findings. Only medical records for members age 36 and over will be audited for this measure.

2. **Colorectal cancer screening** should be performed for members age 50-75, by means of ONE of the following screening options:
   - Fecal occult blood test (FOBT) within the past 12 months (FOBT performed during a physical exam on a specimen obtained from a digital rectal exam does not count, because it is not specific or comprehensive enough to screen for colorectal cancer.)
   - Flexible sigmoidoscopy within the past five years
   - Fecal occult blood annually plus flexible sigmoidoscopy within the past five years
   - Colonoscopy within the past 10 years
   Only medical records for members age 52-75 will be audited for this measure. The chart must include the date, type of test and results.
3. **Influenza Vaccinations** should be administered annually to members at high risk for complications from influenza and to those members age 65 and over. (The medical records audited will include adult members with asthma, diabetes, and CVD and members age 65 and over). Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review. **Ages 50-65 will be audited.**

4. **Discussion regarding prostate cancer screening** should be documented for males age 50 and over. Discussion should include information regarding their risk of prostate cancer and potential benefits and harms of prostate cancer screening. Only medical records for members age 52 and over will be audited for this measure.

C. **Children:**

1. **Immunizations** should be performed according to the Preventive Healthcare Guidelines, which are based on the Recommended Childhood Immunization Schedule, United States, as approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

   Parent refusal of such services should be documented in the medical record. **These will be scored as non-compliant.**

   For members who have transferred from another practitioner, immunization records should be obtained and reviewed for completeness.

   Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine.

   All records for children between the ages of two to five years will be audited. The medical records will be audited and scored for immunizations due between the ages of one and two as identified in Table A. The immunizations audited are: DTaP, IPV, Hib, MMR, Hep B, Varicella, and Pneumococcal.

   **Information will be collected for:**
   
   A.) For children born between 1/1/05 and 12/31/08, the record will be reviewed for at least one influenza vaccination given between the dates 8/1/08 and 3/1/10. **
   
   B.) Records will be audited for at least one Hepatitis A given between one and two years of age. **
   
   C.) Records will be audited for at least one rotavirus given before the first birthday. **

**Denotes non-scored item.
TABLE A

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Birth</th>
<th>2 mo.</th>
<th>4 mo.</th>
<th>6 mo.</th>
<th>12 mo.</th>
<th>15 mo.</th>
<th>18 mo.</th>
<th>2 yr.</th>
<th>4 – 6 yrs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Between 15-18 months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Between 6-18 months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td>X</td>
<td>X</td>
<td>(X)+</td>
<td></td>
<td>Between 12-15 months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Between 12-15 months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Between 6-18 months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Between 12-15 months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td>X</td>
<td>X</td>
<td>(X)+</td>
<td></td>
<td>Two doses between 12 and 23 months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Two doses between 12 and 23 months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate (Prevnar)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Between 12-15 months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Annually age 6-59 months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(X)+ = Whether this dose is needed depends on the brand of vaccine used.

Table B:
Combination Vaccines

<table>
<thead>
<tr>
<th>Immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP + Hep B + IPV</td>
</tr>
<tr>
<td>(Pediarix)</td>
</tr>
<tr>
<td>DTaP + HiB</td>
</tr>
<tr>
<td>(TriHIBit)</td>
</tr>
<tr>
<td>Hep B + HiB</td>
</tr>
<tr>
<td>(Comvax)</td>
</tr>
<tr>
<td>MMR + VZV</td>
</tr>
<tr>
<td>(ProQuad)</td>
</tr>
<tr>
<td>DTaP + IPV+HiB</td>
</tr>
<tr>
<td>(Pentacel)</td>
</tr>
</tbody>
</table>
## Table C: Contraindications for Childhood Immunizations

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Contraindication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any particular vaccine</td>
<td>Anaphylactic reaction to the vaccine or its components</td>
</tr>
<tr>
<td>DTaP</td>
<td>Encephalopathy</td>
</tr>
<tr>
<td>IPV</td>
<td>Anaphylactic reaction to streptomycin, polymyxin B or neomycin</td>
</tr>
<tr>
<td>MMR and VZV</td>
<td>Immunodeficiency, including genetic (congenital) immunodeficiency syndromes</td>
</tr>
<tr>
<td>MMR and VZV</td>
<td>HIV disease; asymptomatic HIV</td>
</tr>
<tr>
<td>MMR and VZV</td>
<td>Cancer of lymphoreticular or histiocytic tissue</td>
</tr>
<tr>
<td>MMR and VZV</td>
<td>Multiple myeloma</td>
</tr>
<tr>
<td>MMR and VZV</td>
<td>Leukemia</td>
</tr>
<tr>
<td>MMR and VZV</td>
<td>Anaphylactic reaction to neomycin</td>
</tr>
<tr>
<td>HiB</td>
<td>None</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Anaphylactic reaction to common baker’s yeast</td>
</tr>
<tr>
<td>Pneumococcal conjugate</td>
<td>None</td>
</tr>
</tbody>
</table>
STANDARDS FOR BEHAVIORAL HEALTH PRACTITIONERS

I. ACCESSIBILITY STANDARDS

Purpose:
To evaluate whether members have appropriate access to Behavioral Health services.

Procedure:
A. BCBSIL has specific service expectations for participating Behavioral Health Care Practitioners. They are as follows:

1. Provide and/or refer for life-threatening emergency care.
2. Provide and/or refer for non-life-threatening emergency care within six hours.
3. Schedule and provide urgent care within 24 hours.
4. Schedule routine appointments within 10 business days or within two weeks of request, whichever is sooner. This includes initial evaluation.
5. Arrange for an answering system after office hours that members can access through the usual office protocol:
   ⇒ Response to emergency phone calls should be within 30 minutes.
   ⇒ Response to urgent phone calls should be within one hour.
   ⇒ For life-threatening emergencies, members should be referred to the appropriate Health Care Facility.

6. Arrange for telephone access to screening and triage, if applicable, as follows:
   ⇒ Callers reach a non-recorded voice within 30 seconds and
   ⇒ Abandonment rates do not exceed five percent at any given time.

II. SITE STANDARDS FOR BEHAVIORAL HEALTH

Purpose:
To assess whether members receive Behavioral Health care services in a clean and safe environment.

Procedure:
1. Environment:
   − The site should be clean and well organized to accommodate patient services.
   − Restrooms, doorways and hallways should be easily accessible.
   − The waiting room should have adequate seating for the volume of patients.
   − The site should be accessible to those with disabilities:
There should be at least one entrance to the office that is accessible to those with impaired mobility or those in a wheelchair. Please note: The building must be compliant with ADA (American Disabilities Act) guidelines. If any ADA guideline is not met, the practitioner will have two years from the date of the site review to become compliant with the ADA guideline. Continued non-compliance with the guideline(s) may result in departicipation from the HMO network(s).

- There should be at least one exam room that can be accessed by doorways and hallways that are at least 36 inches wide.
- There should be at least one restroom that can be accessed by doorways and hallways that are at least 36 inches wide.

2. Safety Measures:
   - Sharp disposal containers must be available (if applicable).
   - Fire Extinguisher must be accessible.

3. Medication Maintenance/Storage:
   - Sample drugs, over-the-counter medications, prescription drugs, and vaccines (if applicable) should be stored in restricted patient areas*
   - Controlled substances, if present, should be stored in a locked area along with an Inventory list.
   - **Offices should have policies and procedures for checking medications for expiration dates, and for discarding expired medications.**
   - All medications should be routinely monitored for expiration dates.
   - **Opened medications should be labeled with the date the item was opened.**

4. Medical Supply Maintenance/Storage:
   - Sharps should be stored in restricted patient areas* (if applicable)
   - Prescription pads should be stored in restricted patient areas* (if applicable)

5. Medical Record System:
   - Medical records should be handled in a confidential manner. The office must have a written policy that addresses HIPAA requirements regarding Protected Health Information (PHI).
   - **The office must have a confidentiality of medical records policy and follow the policy.**
   - The practitioner should have a written policy/procedure detailing how medical record information is to be released.

6. Patient Education:
   - Educational materials or literature regarding at least two (mental health or chemical dependency related conditions) medical conditions relevant to the practitioner’s practice must be available for patient use.

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*Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.
**Indicates non-scored item.
III. EMERGENCY PREPAREDNESS

Procedure:

1. Emergency Preparedness

--- The Practitioner should have a written procedure on how to handle a medical emergency for members accessing care at his/her facility. This procedure must be posted in a prominent location or easily accessible through a central file/manual.**

IV. Medical Record Review for Behavioral Health Practitioners

Purpose:

BCBSIL requires member medical records to be maintained in a manner that is current, detailed, organized, and easily accessible. All patient data should be filed in the medical record, (i.e., lab, x-ray, consultation notes, etc.) Documentation of a member’s care should facilitate communication, coordination and continuity of care and promote efficiency and effectiveness of treatment.

Procedure:

Please note: A history form can include many of the required documentation items. This form can be completed by the patient, office staff or practitioner. The practitioner should review the form for completeness, sign and date the form. Blank areas on the form will be scored as non-compliant. The form must be updated at least every three years for adults and at least every five years for the pediatric patient.

1. Past Medical History: There should be documentation of a past medical history obtained by the third visit or within one year of the first visit, whichever comes first. The past medical history should be updated at least every three years for adults and every five years for pediatric patients.

2. Family History: There should be documentation of a family medical history obtained by the third visit or within one year of the first visit, whichever comes first. The family medical history should be updated at least every three years for adults and every five years for pediatric patients.

3. Social History: There should be documentation of a social history (including, but not limited to, information about family and occupation, and assessment of cigarette, tobacco, alcohol and illicit substance use) obtained by the third visit or within one year of first visit, whichever comes first. For pediatric patients, the developmental milestones may be included. The social history should be updated at least every three years for adults and every five years for pediatric patients.

4. Adult Alcohol Use: There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years. In 2010, annual evaluation of alcohol use will be audited.**

**Indicates non-scored item.
5. **Utilization of an Alcohol Assessment Tool for an Adult:** There should be documentation of the use of an alcohol assessment tool if the patient answers yes to alcohol use.**

6. **Adolescent Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years. *In 2010, annual evaluation of alcohol use will be audited.*

7. **Utilization of an Alcohol Assessment Tool for an Adolescent:** There should be documentation of the use of an alcohol assessment tool if the patient answers yes to alcohol use.**

8. **Adult Inappropriate/Illlicit Substance Use:** There should be documentation regarding inappropriate/illicit substance use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using substances, it should be noted. The history of substance use should be updated at least very three years.

9. **Recommendation for Adult Inappropriate/Illlicit Substance Use Treatment:** Instructions and/or education about recommendation for treatment should be provided to members who are identified as using inappropriate/illicit substances.**

10. **Child/Adolescent Inappropriate/Illlicit Substance Use:** There should be documentation regarding inappropriate/illicit substance use obtained by the third visit or within one year of the first visit, whichever comes first, for children/adolescents age. If the child/adolescent is currently using substances, it should be noted. The history of substance use should be updated at least every three years. *In 2010, annual update of use will be audited.*

11. **Recommendation for Child/Adolescent Inappropriate/Illlicit Substance Use Treatment:** Instructions and/or education about recommendation for treatment should be provided to children/adolescents age who are identified as using inappropriate/illicit substances.**

12. **Chief Complaint/History Relevant to Problem:** Subjective information identifying why the patient is seeking Behavioral Health services should be documented. The description should include pertinent history, symptoms, and other related information.

13. **Mental Status Examination:** A pertinent mental status examination, relevant to the problem should be documented. Mental Status Examination should include a risk assessment documenting the patient's potential for danger to self, danger to others and/or gross impairment. Additional information that should be documented, but will not be scored for 2010, includes *at least three of the following assessments:* appearance, motor evaluation, speech, affect, thought content, thought process, perception, intellect, insight (awareness of illness), orientation, attention span, memory, judgment.**

**Indicates non-scored item.
14. Diagnosis/Assessment: A diagnosis and/or assessment, consistent with the findings, should be documented. Include documentation of a DSM_IV diagnosis.

15. Treatment Plan/Plan of Care: A plan of diagnosis (lab testing, x-rays, etc.) and management (medication dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented. Document goals and estimated timeframes for goal attainment or problem resolution.

*Education relevant to the patient’s conditions or treatment must be documented at least annually.**

16. Previous Problems: Unresolved problems from previous office visits should be addressed in subsequent visits.

17. Continuity of Care, Follow-Up care, Calls or Visits: Follow-up care, communication of test results, calls or visits should be documented to indicate continuity of care.

18. Consultations: Documentation of response/feedback from a referral for consultation to a specialist should be present in the record and should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that the feedback from the specialist has been reviewed.

19. Chart Organization: The Practitioner should maintain a uniform medical record system of clinical recording and reporting with respect to services which includes separate sections for progress notes and the results of diagnostic tests.

20. Biographical Information: Each medical record should contain the patient's address, employer, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant. Biographical information should be updated at least every three years.

21. Patient Identifiers: Patient identifiers should appear on each page of the medical record (patient name or unique ID number).

22. Date and Signature: All entries are to be dated and signed/initialed by the author. Author identification may be a handwritten signature, unique electronic identifier or initials. Include the responsible clinician’s name, professional degree.

23. Legibility: All entries should be legible.

24. Allergy Status: Medication allergies should be noted in a prominent location in the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently and consistently noted. Allergies to environmental allergens, food, pets, etc., should also be noted, as they can affect patient behavior. Allergy histories should be obtained by the first visit and updated at least every three years for adults and every five years for pediatric patients. For 2010, allergies should be updated at least annually.** (This will be scored only for those practitioners who prescribe medication).

**Indicates non-scored item.

Quality Site Visit Standards
25. **Problem List:** There should be a current problem list, either kept separately or within each practitioner progress note. The problem list must be inclusive of all problems whether a separate list or within each practitioner progress note.

26. **Medication List:** There should be a current medication list, either kept separately or within each practitioner progress note. The medication list must be inclusive of all medications whether a separate list or within each practitioner progress note, and include prescription initial or refill dates.

27. **Lab/X-Ray/Diagnostic Results:** The results of all labs, x-rays and diagnostic testing, should be posted in the chart. The reports should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that they have been reviewed.

28. **Lithium Assessment:** If Lithium is prescribed, documentation of annual creatinine, Lithium level and thyroid test results with documentation of any follow-up. (Psychiatrists only).**

   **Depakote Assessment:** If Depakote is prescribed, documentation of annual liver function test results with documentation of any follow-up. (Psychiatrists only).**

29. **Coordination between Behavioral Health Care and Referring Practitioner:** There should be documentation of communication with a signed release of information form allowing for communication between the Behavioral Health Practitioner and referring practitioner. Documentation should include, but not be limited to, follow-up regarding coexisting medical and behavioral disorders and education management. If the member refuses to allow such communication, this should be documented.
MINIMUM SCORE TO PASS SITE VISIT
HMOs of Blue Cross and Blue Shield of Illinois and BlueChoice

Effective January 1, 2010

HMO IPAs and PCPs

2010 Passing Thresholds

<table>
<thead>
<tr>
<th>Standards Category</th>
<th>Current HMO IPA</th>
<th>Current HMO PCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility, Facility, Emergency Care</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Medical Record Review, Preventive</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

NOTE:
Any practitioner failing to meet the minimum passing threshold requirement will be re-audited within six months.

****Any practitioner failing two consecutive site visits must submit a corrective action plan (CAP) within 60 days of receipt of the letter requesting a CAP. Failure to submit a CAP may result in de-participation from the network without a third site visit.

Any practitioner failing three consecutive site reviews may be departed from all networks.
Policy Name: Participating IPA or Practitioner Appeal Process of Failed Quality Improvement (QI) Site Visit Results
Policy Number: Quality Improvement – 2
Effective Date: 12/1/09
Revision Date: Review Date:

Policy:

Blue Cross and Blue Shield of Illinois (BCBSIL) will review and respond to any Independent Physician Association (IPA) written appeal of failed QI site visit results for HMO practitioners.

Purpose:

- To establish guidelines for IPA or practitioner appeal of failed QI site visit audit results
- To allow feedback from IPA or practitioner related to a failed QI audit
- To bring the IPA or practitioner back into compliance with audit standards

Procedure:

A. First Level Appeal

1. The IPA or practitioner has 60 days from the date of receipt of the the QI Site Visit results notification to contact the BCBSIL Onsite department, in writing, of the desire to appeal the failed quality on site audit. This is considered a first level appeal. The Onsite Manager/QI/ UM Project Consultant will send an acknowledgment letter of the appeal to the IPA and practitioner within 15 calendar days.

2. In the IPA or practitioner request for appeal, documentation must be submitted if a failing score is being challenged.

3. The structure of the initial investigation will be determined by the scope of the challenge (appeal):
   a. Facility & Accessibility challenges will require an onsite re-audit.
   b. Emergency Preparedness challenges: copies of CPR cards, emergency plans can be faxed or mailed to the Onsite Department within one week of the audit. If items are not available at the time of the onsite visit, an additional visit will be scheduled in order to note that the CPR card and emergency plans are at the site.
   c. Medical Records and Preventive Health will require an onsite re-audit or a meeting at BCBSIL for review of the actual failed medical records.
   d. If an additional onsite review is required, a nurse (RN) and the original site visit reviewer will perform the onsite review.
4. If after a review a failing score is changed to a passing score in favor of the IPA or practitioner appeal, written notice will be sent by the Onsite Manager/QI/UM Project Consultant with the new results within 10 business days of the determination. If the IPA or practitioner is requesting clarification (standards or methods of scoring) the Onsite Department will be responsible to send this letter. Issues regarding the QI Fund are not included in any written notification to the IPA or practitioner from the Onsite Department.

5. In the event a failing score is maintained from the original audit result, the case will be eligible for a second level appeal.

B. Second Level Appeal

1. For a Second Level Appeal, a meeting at BCBSIL is required. The Onsite Manager/QI/UM Project Consultant or the Provider Network Consultant will arrange the meeting. Other attendees may include the Administrator/Medical Director of the IPA or practitioner, Onsite Staff, a BCBSIL Medical Director (not previously involved) and other staff as required.

2. The IPA or practitioner must bring the originally reviewed medical records plus five additional medical records for review at the appeal.

3. Written findings of the second level appeal will be sent to the IPA or practitioner within 15 calendar days of the final case review.

4. The appeal is considered closed after the second level of appeal. No appeals are heard for passing onsite visit scores.
Policy Name: Collaboration Between Primary Care Physicians (PCPs) and Behavioral Health Practitioners
Policy Number: Quality Improvement - 3
Effective Date: 12/1/09
Revision Date: 
Review Date:

Approval
Signature: 
Medical Director

Policy:
Blue Cross and Blue Shield of Illinois promotes collaboration between medical and behavioral health practitioners.

Purpose/Objectives:
To facilitate continuity and coordination of medical care with behavioral health care.

Procedure:
1. Primary Care Physicians (PCPs) and Behavioral Health Practitioners are encouraged to communicate, with written patient consent, in order to promote continuity and coordination of care.

2. The PCP and Behavioral Health Specialist should request a signed consent for release of information form from the patient to facilitate communication between the PCP and the behavioral health professional for coordination of the patient's care.

3. The consent form should be consistent with current state and federal requirements.

4. Communication should include, but is not limited to:
   - diagnosis
   - treatment
   - referral, (if applicable)
   - relevant co-existing medical and behavioral conditions and
   - medications that have been prescribed, in order to minimize the likelihood of drug interactions and increase the recognition of medication side effects.
Policy Name: Corrective Action for QI Site Visits of Participating Practitioners and IPAs
Policy Number: Quality Improvement - 4
Effective Date: 1/1/10
Revision Date:

Approval Signature: __________________________
Medical Director

HMO Illinois, BlueAdvantage HMO,
Replaces Previous Name HCM QI 2 Corrective Action for QI Site Visits of Participating Practitioners and IPAs
Approved QI: 1/6/10
Approved P&P: 12/10/09

Policy:

Practitioners are reaudited within six months if they fail to meet the site visit threshold. Blue Cross and Blue Shield of Illinois (BCBSIL) will request a written Corrective Action Plan from the Independent Physician Association (IPA) and individual practitioner as a result of failing two consecutive Quality Improvement (QI) site visits.

Purpose/Objectives:

• To ensure compliance with the current Quality Site Visit Standards policy
• To ensure the correction of any quality site visit deficiencies

Guidelines:

2. Quality site visit threshold scores are determined annually by Network Management for the IPA and individual practitioners. The IPA and/or practitioner score is used as part of the payment toward the QI Fund for HMO Products.

3. The On-site Department performs the quality site visits as determined by the credentialing/ Illinois Department of Public Health (IDPH) schedule required for participating HMO Primary Care Physician (PCP) practitioners. Prior to the visit, a confirmation letter and copy of the current Site Visit Standards are faxed or mailed to the practitioner’s office. At the conclusion of the site visit, the on-site staff conducts an exit interview with the practitioner or office contact. The practitioner or office contact is required to sign the field report acknowledging,

• receipt of noted deficiencies, if any
• education provided regarding how the deficiencies can be adjusted to meet the Quality Site Visit Standards

4. A copy of the QI site visit results and corrective action plan (CAP) report is provided to the practitioner and office contact. Quality site visit results are maintained in the site visit database. In addition, a site visit summary report is mailed to each HMO IPA at the end of every quarter.

5. The On-site Department disseminates the results to Network Operations and HMO Provider Network Consultants quarterly. All audit results are also logged into the site visit database.
Corrective Action for QI Site Visits of Participating Practitioners and IPAs
Page 2 of 3

Procedure:

1. The On-site Department reviews the results to determine IPAs and practitioners requiring corrective action. If a practitioner fails the site visit, a reaudit is scheduled within six months. If a practitioner fails two consecutive site visits, the site visit results and deficiency report are mailed to the IPA Administrator and practitioner within six weeks of the visit requesting a Corrective Action Plan.

2. The Corrective Action Plan shall include the following:
   - a statement of the deficiency(ies) being addressed
   - a description of the steps which will be taken to correct the cited deficiencies
   - timeframes for performing key steps in the corrective action plan process
   - identification of the responsible parties
   - a description of the new/revised procedures that will be implemented to guard against reoccurrence of the cited deficiency
   - plans for monitoring compliance with the new procedure
   - acknowledgment of the planned reaudit within six months
   - the signature of the PCP and IPA Medical Director

   The practitioner/ IPA shall direct all requests for assistance concerning the corrective action plan to the BCBSIL on-site staff.

   The practitioner/ IPA must submit the Corrective Action plan within 30 days of receipt of the request for a corrective action plan to:

   Blue Cross and Blue Shield of Illinois  
   QI/Onsite Department, 27th Floor  
   300 E. Randolph  
   Chicago, IL  60601  
   Fax# (312) 228-9060

3. When the corrective action plan is received, it is reviewed and approved by the on-site staff.

4. The On-site Department will re-audit the practitioner within six months after the date the practitioner failed the second consecutive onsite review. The Corrective Action Plan must be received before the third audit will be scheduled. Two on-site auditors will conduct the third review. One of the auditors will be a Registered Nurse. Instead of requesting five medical records for review, the office will be notified and required to have 10 charts available for review. If the practitioner has a passing score after reviewing five medical records, the audit will be concluded. If the practitioner has a failing score, after reviewing five medical records, the additional five medical records will be audited and the final score will be based on auditing the 10 records.

5. If a corrective action plan is not received within 60 calendar days, or if the practitioner fails the third consecutive audit, the IPA and practitioner are notified of the potential departicipation of the practitioner and/or IPA.
6. Departicipation is determined by the Network and brought to the Provider Selection Committee. If departicipation is the determination, the departicipation procedures will be followed as outlined in all managed care contracts. Any practitioner’s departicipation as a result of three consecutive failed site visits would result in reporting to the Healthcare Integrity and Protection Data Bank (HIPDB). Practitioners may reapply to the network after one year of their departicipation date.

7. HMO practitioners passing the site visit are scheduled for a reaudit in two years in order to meet IDPH regulations.

8. Should the practitioner or IPA choose to dispute the findings described, they must do so by submitting a written request for appeal. All related supporting documentation must be received within 30 business days following receipt of the notification of the departicipation determination. All appeals must be sent to Blue Cross BlueShield at the address listed above.
Policy Name: Emergency Room Services
Policy Number: Utilization Management - 1
Effective Date: 4/1/10
Revision Date: Review Date:

Approval Signature:

Senior Medical Director
HMOI, BA HMO,
Replaces HCM UM 13 Emergency Room Services
Vice President– Network Management
Approved QI: 4/7/10
Approved P&P: 3/11/10

Policy:

Blue Cross and Blue Shield of Illinois complies with state legislative requirements that emergency room services are covered in accordance with prudent layperson standards. HMO members are financially responsible for emergency room co-payments when not admitted to the hospital as a result of the emergency room visit.

Purpose:

- To outline financial responsibility for emergency claims
- To detail how members can access emergency services

Definitions:

- Prudent layperson - a person who has an average knowledge of health and medicine.

- Emergency Medical Condition - a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:
  a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  b. serious impairment to bodily functions; or
  c. serious dysfunction of any bodily organ or part.

Procedure:

HMO

1. A member experiencing an emergency medical condition:
   - may or may not contact his Primary Care Physician (PCP) for guidance. Note: If contacted, for HMO Independent Physician Associations (IPAs), the HMO PCP is responsible for coordinating and/or authorizing “in area” emergency services which is defined as those medical services and supplies provided within a 30-mile radius of the IPA or IPA affiliated hospital site in which the member is enrolled.
   - has the option to go to an emergency room without prior guidance from or authorization by the PCP if he is experiencing an emergency as defined using the prudent layperson definition.

2. Prior authorization or approval by the contracting Independent Practice Association (IPA) or PCP is not required for a member’s emergency services.
3. The contracting IPA will pay for all physicians and other professional charges for emergency services provided to a member within a 30-mile radius of the IPA or IPA affiliated hospital site in which the member is enrolled.

4. Unless referred by the IPA PCP, the contracting IPA is not responsible for physician and other professional charges for emergency services provided to a member outside of the 30-mile radius of the IPA or IPA affiliated hospital site in which the member is enrolled.

5. The HMO is always responsible for facility charges related to emergency room services.

6. Unless referred by the IPA PCP, the HMO is responsible for all professional fees related to an emergency visit outside of the 30 mile radius of the IPA or IPA affiliated hospital site in which the member is enrolled.

7. If the member is hospitalized as a result of an emergency medical condition within a 30-mile radius of the IPA or IPA affiliated hospital in which the member is enrolled:
   - All inpatient units will be charged to the contracting IPA.
   - The HMO is responsible for all professional fees prior to the IPA’s point of notification and the contracting IPA is responsible for all “in-area” inpatient physician and professional fees from the point of notification.

   **Note: The in-area emergency room professional fees are the IPA’s financial risk regardless of point of notification.**

8. If the member is hospitalized outside of the 30-mile radius of the IPA or IPA affiliated hospital site in which the member is enrolled as a result of an emergency medical condition:
   - The HMO is responsible for all physician and other professional charges.
   - Inpatient units will not be charged to the contracting IPA.