Table of Contents


Purpose and Introduction .................................................. 6
Blue Cross and Blue Shield of Georgia (BCBSGa) ........................ 7
Future Updates ...................................................................... 7

Legal and Administrative Requirements Overview

Dispute Resolution and Arbitration ........................................ 7
Facility Based Physicians ..................................................... 8
Home Delivery Pharmacy Prescription Drug Program ................. 9
Insurance Requirements ....................................................... 9
Laboratory Tests .................................................................. 10
Non-Compliance Policy ....................................................... 10
NPI – National Provider Identifier ......................................... 11
Open Practice ...................................................................... 11
Physician Rights and Responsibilities ........................................ 11
Preferred Drug List .............................................................. 12
Release of Information/Confidentiality ....................................... 12
Responsibilities of the Facility ............................................... 12
Risk Adjustments .................................................................. 13
RADV Audits ...................................................................... 14
ICD-10 CM Codes ................................................................ 14

Gatekeeper HMO Specific Guidelines

Role of Primary Care Physician ............................................... 14
Covered Individual Selection of a PCP ....................................... 15
PCP Scope of Services ........................................................... 15
Missed Physician Appointments .............................................. 17
Terminating a Physician-Patient Relationship ............................ 17
Access Standards .................................................................. 18
Role of Specialty Care Physician .............................................. 18
Verify Covered Individual Eligibility ........................................ 19
Specialist to Specialist Referrals .............................................. 20
Self-Referrals by Covered Individuals ....................................... 20
OBGYN Specific Information .................................................. 20
Covering Physician(s) ............................................................. 22
Covered Individual Copayment ............................................... 23
Primary Care Physician Reimbursement .................................... 24
Encounter Reporting .............................................................. 24
Discounting acceptance of New Patients ................................. 24
Changes to Practice ................................................................ 24
Covered Individuals and Enrollment ......................................... 24

Directory of Services

Quick Reference Guide ........................................................... 25
BlueCard/ITS ...................................................................... 29
Provider Contracting and Provider Relations ............................ 29

Provider Access

ProviderAccess® ................................................................... 29
Availity ................................................................................. 30
Payer Spaces ........................................................................ 31
Interactive Care Reviewer (ICR) ............................................... 31

Eligibility

Covered Individual Identification and Verification ....................... 32
On-line Access ................................................................. 32
Covered Individual ID Card ............................................... 32
Provider Service Line ....................................................... 43
Electronic Inquiry ................................................................ 44
Checking Claim Status .......................................................... 44

Claims Submission

HMO/POS and Blue Open Access ............................................. 44
Filing Claims-All Products ...................................................... 44
Ancillary Claims Filing .......................................................... 45
Electronic Claim Acceptance/Rejection Validation .................. 46
Requests for Clinical Information .......................................... 46
Clinical Submission Categories ............................................. 46
Claims Processing ............................................................... 47
Ambulatory Surgery Center billing requirement .................. 48
Electronic Data Interchange (EDI) Overview ......................... 48
Provider and Facility Identified Overpayments .................... 48

Reimbursement and Billing Policies

Medicare Care Provided to or by Family Members .................. 49
Changes During Admission ................................................... 50
Claim Payment .................................................................. 50
Coordination of Benefits/Subrogation .................................... 50
Co-Payments, Co-insurance and Deductibles ......................... 50
Eligibility and Payment ....................................................... 51
Facility Personnel Charges ................................................... 51
General Industry Standard Language .................................... 51
Implants ........................................................................... 51
Labor Care Charges ............................................................ 51
Observation Services Policy .................................................. 52
Non-Covered Use of Observation Beds ................................... 53
Observation Services, Proper Billing of ................................. 53
Personal Care Items ............................................................ 53
Preventable Adverse Events ("PAE") Policy ............................ 53
Reimbursement ................................................................. 56
Remittance Advice Reconciliation ........................................ 56
Test or Procedures Prior to Admission(s) or Outpatient Services 56

Medical Policies

Medical Policies ................................................................ 55

Utilization Management

Utilization Management Program ........................................... 57
Preservice Review & Continued Stay Review ......................... 57
Medical Policies and Clinical UM Guidelines Link ................ 57
On-Site Continued Stay Review ............................................ 57
Discharge Planning ............................................................. 57
Observation Bed Policy ....................................................... 58
Retrospective Utilization Management ................................ 58
Failure to Comply with Utilization Management Program .......... 58
Case Management ............................................................ 58
Utilization Statistics Information ......................................... 58
Electronic Data Exchange .................................................... 58
Reversals ......................................................................... 58
Peer to Peer Review Process ................................................ 59
Quality of Care Incident ...................................................... 59
Audits/Records Requests ..................................................... 59
UM Definitions .................................................................. 59
## Credentialing

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentialing Scope</td>
<td>60</td>
</tr>
<tr>
<td>Credentials Committee</td>
<td>61</td>
</tr>
<tr>
<td>Nondiscrimination Policy</td>
<td>62</td>
</tr>
<tr>
<td>Initial Credentialing</td>
<td>59</td>
</tr>
<tr>
<td>Recredentialing</td>
<td>63</td>
</tr>
<tr>
<td>Health Delivery Organizations</td>
<td>64</td>
</tr>
<tr>
<td>Ongoing Sanction Monitoring</td>
<td>64</td>
</tr>
<tr>
<td>Appeals Process</td>
<td>64</td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td>65</td>
</tr>
<tr>
<td>BCBSGa Credentialing Program Standards</td>
<td>69</td>
</tr>
</tbody>
</table>

## Quality Improvement Program

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement Programs Overview</td>
<td>75</td>
</tr>
<tr>
<td>Service Quality</td>
<td>76</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>77</td>
</tr>
<tr>
<td>Quality-In-Sights® Hospital Incentive Program (Q-HIP SM)</td>
<td>78</td>
</tr>
<tr>
<td>Quality-In-Sights® Primary Care Incentive Program</td>
<td>78</td>
</tr>
<tr>
<td>Performance Data</td>
<td>78</td>
</tr>
<tr>
<td>Clinical Practice Guidelines</td>
<td>78</td>
</tr>
<tr>
<td>Preventive Health Guidelines</td>
<td>79</td>
</tr>
<tr>
<td>Covered Individual Safety</td>
<td>79</td>
</tr>
<tr>
<td>Partnership for Health and Accountability</td>
<td>79</td>
</tr>
<tr>
<td>Health Insurance Portability &amp; Accountability Act (HIPAA)</td>
<td>80</td>
</tr>
<tr>
<td>Additional Quality Management Program Information</td>
<td>80</td>
</tr>
</tbody>
</table>

## HEDIS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of HEDIS</td>
<td>80</td>
</tr>
</tbody>
</table>

## CAHPS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of CAHPS</td>
<td>80</td>
</tr>
</tbody>
</table>

## Cultural Diversity

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Diversity Overview</td>
<td>81</td>
</tr>
<tr>
<td>Learning Opportunities</td>
<td>82</td>
</tr>
<tr>
<td>Cultural competency training</td>
<td>83</td>
</tr>
<tr>
<td>Medical Records Standards</td>
<td>84</td>
</tr>
</tbody>
</table>

## Centers of Medical Excellence

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant</td>
<td>85</td>
</tr>
<tr>
<td>Cardiac Care</td>
<td>85</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>85</td>
</tr>
<tr>
<td>Complex and Rare Cancers</td>
<td>86</td>
</tr>
<tr>
<td>Spine Surgery</td>
<td>86</td>
</tr>
<tr>
<td>Knee and Hip Replacement</td>
<td>87</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>87</td>
</tr>
</tbody>
</table>
## Covered Individual Grievance and Appeal Process

- Covered Individual Complaints about Service: 87
- Covered Individual Appeals Process: 87

## Provider Complaint and Appeals Process

- Provider Complaint and Appeal Decisions: 88
- Claims Payment Issues: 88
- Provider Administration Issues: 88
- Appeal of Utilization Management Decisions: 88
- Appeal of Urgent and/or Concurrent Decisions: 89

## Member Quality of Care (“QOC”) Investigations

- Overview: 89
- Corrective Action Plans (CAP): 90
- Reporting: 90
- Severity Levels for Quality Assurance: 90
- Trend Thresholds for Analysis: 91

## Product Summary

- ACA – complaint health plans: 91
- PPO Network Overview: 92
- HMO Network Overview: 93

## BlueValue Secure

- BlueValue Secure Provider Website: 94

## Audit

- Audit Policy: 94
- Audit Appeal Policy: 98

## Fraud, Waste and Abuse

- Fraud, Waste and Abuse Detection: 99
- Pre-Payment Review Program: 99

## Federal Employee Health Benefit Program (FEHBP)

- FEHBP Requirements: 100
- Submission of Claims under FEHBP: 100
- Errors of Duplicate Claim payments under FEHBP: 100
- Coordination of Benefits for FEHBP: 100
- FEHBP Waiver requirements: 101
- FEHBP Member Reconsiderations and Appeals: 101
- FEHBP Formal Provider and Facility Appeals: 101

## BlueCard Program Overview

- BlueCard Program Overview: 102

## Health Insurance Marketplace (Exchanges)

- Health Insurance Marketplace: 102
### Purpose and Introduction

This Manual is intended to support all entities and individuals that have contracted with BCBSGa. The use of “Provider” within this manual refers to entities and individuals contracted with BCBSGa that bill on a CMS 1500. They may also be referred to as Professional Providers in some instances. The use of “Facility” within this manual refers to entities contracted with BCBSGa that bill on a UB 04, such as Acute General Hospitals and Ambulatory Surgery Centers. General references to “Provider Inquiry”, “Provider Website”, “Provider Network Manager” and similar terms apply to both Providers and Facilities.
The policies and procedures described in the provider manual apply to our Traditional/Indemnity, BlueChoice PPO and BlueChoice Healthcare Plan (HMO/POS) and BlueChoice Options (HMO/POS) — including Blue Open Access products. The terms “Blue Cross and Blue Shield of Georgia”, “BCBSGa” and “Plan” refer to these products collectively. Information about Blue Value Secure (our Medicare Advantage HMO product) may be found by referring to the Blue Value Secure Provider Manual.

Blue Cross and Blue Shield of Georgia (BCBSGa)

The Blue Cross and Blue Shield of Georgia (“BCBSGa”) provider manual is a comprehensive document designed to inform Providers and Facilities of BCBSGa Claim submission guidelines and requirements. In addition, the manual includes, but is not limited to, administrative procedures such as eligibility, admission processes, descriptions and explanations of the remittance advice, utilization management (“UM”) guidelines and other helpful information.

BCBSGa is committed to providing Providers with an accurate and up-to-date provider manual; however, there may be instances where new procedures or processes are not immediately reflected in the manual. In such cases, BCBSGa will make every effort to distribute updated documentation in the next manual update. In those instances that information in this manual differs from that in the Agreement, the Agreement will take precedence over the manual.

We appreciate your participation in the BCBSGa Network(s). BCBSGa is committed to working with Providers and Covered Individuals to provide a high level of satisfaction in delivering quality health care. The BSBSGa provider manual is an integral part of this commitment.

Future Updates
As necessary, we will update the manual at bcbsga.com to provide you with the most current Blue Cross and Blue Shield procedures and policies.

Legal and Administrative Requirements Overview

Dispute Resolution and Arbitration

The substantive rights and obligations of BCBSGa, Providers and Facilities with respect to resolving disputes are set forth in the BCBSGa Provider Agreement (the "Agreement") or the BCBSGa Facility Agreement (the "Agreement"). All administrative remedies set forth above shall be exhausted prior to filing an arbitration demand. The following provisions set forth some of the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement.

A. Attorney’s Fees and Costs

The shared fees and costs of the non-binding mediation and arbitration (e.g. fee of the mediator, fee of the independent arbitrator, etc.) will be shared equally between the parties. Each party shall be responsible for the payment of that party’s specific fees and costs (e.g. the party’s own attorney’s fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.). Notwithstanding this provision, the arbitrator may issue an order in accordance with Federal Rule of Civil Procedure Rule 11.

B. Location of the Arbitration

The arbitration hearing will be held in the city and state in which the BCBSGa office, identified in the address block on the signature page to the Agreement, is located except that if there is no address block on the signature page, then the arbitration hearing will be held in the city and state in which the BCBSGa Plan has its principal place of business. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location.

C. Selection and Replacement of Arbitrator(s)

For disputes equal to or greater than (exclusive of interests, costs or attorney’s fees) the dollar thresholds set forth in the Dispute Resolution and Arbitration Article of the Agreement the panel shall be selected in
the following manner. The arbitration panel shall consist of one (1) arbitrator selected by Provider/Facility, one (1) arbitrator selected by BCBSGa, and one (1) independent arbitrator to be selected and agreed upon by the first two (2) arbitrators. If the arbitrators selected by Provider/Facility and BCBSGa cannot agree in thirty (30) calendar days on who will serve as the independent arbitrator, then the arbitration administrator identified in the Dispute Resolution and Arbitration Article of the Agreement shall appoint the independent arbitrator. In the event that any arbitrator withdraws from or is unable to continue with the arbitration for any reason, a replacement arbitrator shall be selected in the same manner in which the arbitrator who is being replaced was selected.

D. Discovery

The parties recognize that litigation in state and federal courts is costly and burdensome. One of the parties’ goals in providing for disputes to be arbitrated instead of litigated is to reduce the costs and burdens associated with resolving disputes. Accordingly, the parties expressly agree that discovery shall be conducted with strict adherence to the rules and procedures established by the mediation or arbitration administrator identified in the Dispute Resolution and Arbitration Article of the Agreement, except that the parties will be entitled to serve requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34.

E. Decision of Arbitrator(s)

The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of the Agreement and shall be bound by and follow controlling law including, but not limited to, any applicable statute of limitations, which shall not be tolled or modified by the Agreement. If there is a dispute regarding the applicability or enforcement of the class waiver provisions found in the Dispute Resolution and Arbitration Article of the Agreement, that dispute shall only be decided by a court of competent jurisdiction and shall not be decided by the arbitrator(s). Either party may request a reasoned award or decision, and if either party makes such a request, the arbitrator(s) shall issue a reasoned award or decision setting forth the factual and legal basis for the decision.

The arbitrator(s) may consider and decide the merits of the dispute or any issue in the dispute on a motion for summary disposition. In ruling on a motion for summary disposition, the arbitrator(s) shall apply the standards applicable to motions for summary judgment under Federal Rule of Civil Procedure 56.

Judgment upon the award rendered by the arbitrator(s) may be confirmed and enforced in any court of competent jurisdiction. Without limiting the foregoing, the parties hereby consent to the jurisdiction of the courts in the State(s) in which BCBSGa is located and of the United States District Courts sitting in the State(s) in which BCBSGa is located for confirmation and injunctive, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

A decision that has been appealed shall not be enforceable while the appeal is pending.

F. Confidentiality

Subject to any disclosures that may be required or requested under state or federal law, all statements made, materials generated or exchanged, and conduct occurring during the arbitration process including, but not limited to, materials produced during discovery, arbitration statements filed with the arbitrator(s), and the decision of the arbitrator(s), are confidential and shall not be disclosed in any manner to any person who is not a director, officer, or employee of a party or an arbitrator or used for any purpose outside the arbitration. If either party files an action in federal or state court arising from or relating to a mediation or arbitration, all documents must be filed under seal to ensure that confidentiality is maintained. Nothing in this provision, however, shall preclude BCBSGa or its parent company from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.

Facility Based Physicians
Facility based physicians are physicians, with the exception of residents, interns and fellows, who have a contractual relationship with one or more Facilities to provide professional services. These services may be of either of the following types: (1) administrative, managerial, teaching, or quality management activities compensated by the Facility and that are furnished to the Facility or its general population; or (2) physician services personally rendered to a Covered Individual while in the Facility that directly contribute to the diagnosis or treatment of a Covered Individual and which ordinarily require performance by a physician, including but not limited to, an emergency room physician, radiologist, pathologist, neonatologist, hospitalist or anesthesiologist. Facility based physicians do not include Primary Care Physicians (“PCP”) or Specialty Care Physicians who are employed by the Facility and have a separate contractual agreement with BCBSGa. 

BCBSGa and Facility will make commercially reasonable efforts to require each of the contracted or employed facility based physicians to maintain an Agreement, as appropriate, with BCBSGa at the current BCBSGa market rates. When a new Facility based physician (or group of physicians) joins the facility, the Facility shall be provided sixty (60) days to cause such Facility based physicians to execute Agreement(s) with BCBSGa. Until such time as Facility-based physicians enter into agreements with BCBSGa, Facility agrees to fully cooperate with BCBSGa to prevent Covered Individuals from being billed amounts in excess of the applicable BCBSGa non-participating reimbursement for such Covered Services. Facility-based physicians may include, but are not limited to, anesthesiologists, radiologists, pathologists, neonatologists, hospitalists and emergency room physicians.

In addition, the Facility shall take any action necessary to ensure that its contracted Facility based physicians cooperate with, participate in and are bound by the BCBSGa utilization and quality management programs and coordinate as appropriate with the admitting physician and PCP.

**Home Delivery Pharmacy Prescription Drug Program**

Covered Individuals covered under a Prescription Drug Program may have maintenance prescriptions filled through the Express Scripts’ Home Delivery pharmacy.

Maintenance drugs are defined as: approved by the FDA for long-term use for chronic conditions; considered reasonably safe when dispensed in large quantities of up to a 90-day supply; and must not have a potential for abuse.

Maintenance prescriptions may be written for up to a ninety (90) day supply with refills.

For NEW maintenance medications it is recommended that the PCP write two prescriptions:

- one for up to a ninety (90) day* supply plus refills, to be mailed to our designated Pharmacy Benefit Manager and
- a second one, for a thirty (30) day supply, to be filled immediately at a retail pharmacy.

*Note: By law, Home Delivery Pharmacy must fill the prescription for the exact quantity of medication prescribed (e.g., “30 days plus two refills” does not equal one prescription written for “90 days.”)

BlueChoice providers and Covered Individuals may call BCBSGa Customer Service regarding this program.

**Insurance Requirements**

A. Providers and Facilities shall, during the term of this Agreement, keep in force with insurers having an A.M. Best rating of A minus or better, or self-insure, the following coverage:

1. Professional liability/medical malpractice liability insurance which limits shall comply with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render those services addressed by this Agreement. In states where there is an applicable statutory cap on malpractice awards, Providers and Facilities shall maintain coverage with limits of not less than the statutory cap.
If this insurance policy is written on a claims-made basis, and said policy terminates and is not replaced with a policy containing a prior acts endorsement, Providers and Facilities agree to furnish and maintain an extended period reporting endorsement ("tail policy") for the term of not less than three (3) years.

2. Workers’ Compensation coverage with statutory limits and Employers Liability insurance.

3. Commercial general liability insurance for Providers and Facilities for bodily injury and property damage, including personal injury and contractual liability coverage.

For Ambulance/Medical Transportation Providers Only, in addition to the above:

- Auto Liability insurance which complies with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render services...

For Air Ambulance Providers Only, in addition to the above:

- Aviation Liability insurance with limits of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate.

Acceptable self-insurance can be in the form of a captive or self-management of a large retention through a Trust. A self-insured Provider or Facility shall maintain and provide evidence of a valid self-insurance program consisting of at least one of the following upon request:

1. Actuarially validated reserve adequacy for incurred Claims, incurred but not reported Claims, and future Claims based on past experience;
2. Designated claim third party administrator or appropriately licensed and employed claims professional or attorney;
3. Evidence of surety bond, reserve or line of credit as collateral for the self-insured limit.

B. Providers and Facilities shall notify BCBSGa of a reduction in, cancellation of, or lapse in coverage within ten (10) days of such a change. A certificate of insurance shall be provided to BCBSGa upon execution of this Agreement and upon request during the Agreement period.

Laboratory Tests

Laboratory testing must be sent to a BCBSGa in-network laboratory provider. Any lab work referred to an out-of-network laboratory without approval prior to services being rendered, will be the financial responsibility of the referring physician.

To the extent the physician draws any lab work or performs any laboratory diagnostic testing in his/her office for any patient, the physician shall perform such in-office testing for BCBSGa Covered Individuals. Patient service centers are to be used only by Providers who do not draw any lab work in their office.

Laboratory Corporation of America ("LabCorp") is the reference laboratory provider for HMO, Open Access POS Covered Individuals. All laboratory testing for HMO, Open Access POS Covered Individuals must be referred to LabCorp except those that have been approved as in-office laboratory tests. Approved in-office laboratory procedure codes will be reviewed periodically for additions, deleted and replacement codes.

LabCorp requisition forms must be completed and accompany the Covered Individual to the patient service center. Please ensure the requisition is completed correctly. Go to www.labcorp.com for LabCorp’s laboratory requisition procedures and to search for LabCorp Patient Service Centers.

Non-Compliance Policy

The purpose of the Non-Compliance Policy is to monitor and assure compliance with BCBSGa administrative and UM policies and operational requirements pursuant to Agreements with Providers.

BCBSGa will notify Provider of any documented occurrence of administrative non-compliance with their agreement. BCBSGa will track occurrences and provide notification and necessary education to the Provider.
Examples of administrative non-compliance include, but are not limited to:

- Balance billing Covered Individuals when Covered Individual has no financial liability,
- Failure to use/call in a network physician to admit a BCBSGa Covered Individual from the emergency room,
- Referral of a Covered Individual to an out-of-network provider,
- Failure to obtain required pre-authorization for admissions and/or procedures,
- Failure to provide timely information for prospective reviews,
- Failure to call in a Network physician for a specialist consultation,

Please contact your provider representative with questions regarding the non-compliance policy.

National Provider Identifier (“NPI”)

The National Provider Identifier (“NPI”) is a component of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The NPI is a ten (10) digit single provider identification number the Centers for Medicaid and Medicare Services (“CMS”) assigns through the National Plan and Provider Enumerator System (“NPPES”) to uniquely identify a physician, other health care professional or institution within specified electronic HIPAA transactions. It is intended to improve the efficiency of the health care system and reduce fraud and abuse.

The NPI has replaced all existing identification numbers including the Medicare, Medicaid, Unique Physician Identification Number (“UPIN”) and plan provider identification numbers.

Please note if NPI numbers submitted are INVALID, we will be unable to complete the processing of your Claim(s). Your correct tax identification number (“TIN”) and billing address must be included when filing a Claim.

Open Practice

Provider shall give Plan sixty (60) days prior written notice when Provider no longer accepts new patients.

Physician Rights and Responsibilities

Providers have the right to:

- Request that a Covered Individual be reassigned if an acceptable physician-patient relationship cannot be established
- Receive timely payment for Covered Services according to their Agreement
- Be treated courteously and with respect by BCBSGa Covered Individuals and personnel
- Obtain all necessary information to treat Covered Individuals
- Express their opinions, concerns, or complaints in a constructive and respectful manner to BCBSGa
- File an appeal and be given due process
- Collect any Cost Shares for Covered Services
- Collect for non-Covered Services, with proper disclosure
- Discuss, based on their opinions, all Medically Necessary or appropriate care with Covered Individuals.

BCBSGa Providers have a responsibility to:

- Cooperate with all BCBSGa administrative, quality, and UM guidelines and programs
- Ensure that the confidentiality of medical information is protected
- Treat Covered Individuals and BCBSGa personnel with courtesy and respect
- Seek only authorized Cost Shares and specifically authorized payments for non-Covered Services from BCBSGa Covered Individuals
- Strive to improve the health of all Covered Individuals by offering and providing all necessary preventive services appropriate to their specialty
- Discuss a Covered Individual's health care status and treatment options with that Covered Individual or his or her legal guardian, regardless of whether the information concerns a Covered Service
- When a Covered Individual requests it, disclose a general description of the way their BCBSGa reimbursement Agreement works
- Respond to Covered Individual requests for specific information about their practice, including practice statistics (i.e. the numbers of a specific procedure performed), their credentials (i.e. where they went to medical school, board certification), and patient satisfaction measures.

**Preferred Drug List**

The objective of the Preferred Drug List (often referred to as “Preferred Drug Formulary”) is to ensure quality and cost-effective prescription drug coverage at an affordable price for our Covered Individuals. The Pharmacy and Therapeutics (“P&T”) Committee, composed of practicing physicians and pharmacists, has selected safe and effective products for coverage under the Preferred Drug List. The Preferred Drug List is supported by sound medical guidelines and treatment protocols researched from current pharmacological literature, reference books and peer-reviewed journals.

The Preferred Drug List includes coverage for many single-source brand name drugs, essentially all generic equivalent products, and some multi-source brand agents. The Preferred Drug List also targets our most highly-utilized therapeutic categories. Within these top classes, single-source brand name drugs are limited to a specific list. Those drugs not included on the Preferred Drug List are considered non-preferred or non-formulary. Non-preferred agents are not considered a covered prescription benefit unless they meet criteria established by the P&T Committee and approved by the Plan. The BCBSGA Prescription Drug Program includes an exception process to provide coverage for a non-preferred drug prescribed by you when, in your professional judgment, no effective alternative is available on the Preferred Drug List. This process documents the need for an exception when a formulary/preferred product has been proven to be ineffective or causes adverse or harmful reactions to the patient. Please see our web site, www.bcbsga.com, for more details.

As a Provider, you are asked to prescribe products from the Preferred Drug List for all BCBSGa Covered Individuals. By prescribing preferred drugs when appropriate, you help contain the rising costs of health care, ensure the use of high quality pharmaceuticals, and help maintain your patients’ continued drug coverage. We also ask that you assure your patients of the safety and efficacy of generic equivalents. Please use the Preferred Drug List when prescribing for your BCBSGa patients. To receive a copy of the most current Preferred Drug List, please go to www.bcbsga.com or contact your local Network Management Consultant.

Specific drugs may require preauthorization. Specific preauthorization request form will apply to these drugs. The drug-specific preauthorization forms are available on our web site at www.bcbsga.com.

**Release of Information/Confidentiality**

Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all Covered Individual information received from BCBSGa to ensure no misrouted PHI is included. Misrouted PHI includes information about Covered Individuals that a Provider or Facility is not currently treating. PHI can be misrouted to Providers or Facilities by mail, fax or email. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact your local Provider Representative to report receipt of misrouted PHI.

**Responsibilities of the Facility**

A Facility must promptly notify BCBSGa of:
- Any change or notification of possible change in its state licensure,
- Any change in accreditation status by The Joint Commission (“TJC”) or Medicare certification;
- Any change in its ownership or business address;
Any legal or governmental action or any other problem or situation which might impair the ability of Facility to carry out its duties and obligations under its BCBSGa Agreement(s) including, but not limited to, employee strikes or walkouts, financial insolvency, or damage to the physical plant resulting in any interruption in medical services;

- Any written complaint, claim or suit or threat of legal action by a Covered Individual against the Facility or the Facility’s medical staff;
- Any action taken by Facility or its medical staff against a physician;
- Any change or notification of possible change in professional licensure of staff member or a physician; and
- Any change or notification of possible change in Facility’s comprehensive general or professional liability insurance limits. If Facility reserves funds to meet the insurance requirements; Facility shall notify BCBSGa of any change in the reserves.

A Facility must provide at least one hundred twenty (120) days prior written notice of the intention to add, limit or delete any Facility or service. This would include the addition of any freestanding Facilities.

**Risk Adjustments**

**Compliance with Federal Laws, Audits and Record Retention Requirements**

Medical records and other health and enrollment information of Covered Individuals must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular Covered Individual;
- Maintain such records and information in a manner that is accurate and timely; and
- Identify when and to whom Covered Individual information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a Covered Individual, BCBSGa, Providers and Facilities are obligated to abide by all Federal and state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

**Encounter Data for Risk Adjustment Purposes**

Commercial Risk Adjustment and Data Submission: Risk adjustment is the process used by Health and Human Services (“HHS”) to adjust the payment made to health plans under the Affordable Care Act (“ACA”) based on the health status of Covered Individuals who are insured under small group or individual health benefit plans compliant with the ACA (aka “ACA Compliant Plans”). Risk adjustment was implemented to pay health plans more accurately for the predicted health cost expenditures of Covered Individuals by adjusting payments based on demographics (age and gender) as well as health status. BCBSGa, as a qualifying health plan, is required to submit diagnosis data collected from encounter and claim data to HHS for purposes of risk adjustment. Because HHS requires that health plans submit all ICD10 codes for each beneficiary, BCBSGa also collects diagnosis data from the Covered Individuals’ medical records created and maintained by the Provider or Facility.

Under the HHS risk adjustment model, the health plan is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician/qualified non-physician e.g. nurse practitioner encounters only.

Maintaining documentation of Covered Individuals’ visits and of Covered Individuals’ diagnoses and chronic conditions helps BCBSGa fulfill its requirements under the Affordable Care Act. Those requirements relate to the risk adjustment, reinsurance and risk corridor, or “3Rs” provision in the ACA. To ensure that BCBSGa is reporting current and accurate Covered Individual diagnoses, Providers and Facilities may be asked to complete an Encounter Facilitation Form (also known as a SOAP note) for Covered Individuals insured under small group or individual health benefit plans suspected of having unreported or out of date condition information in their records. BCBSGa’s goal is to have this information confirmed and/or updated no less than annually. As a condition of the Facility or Provider’s Agreement with BCBSGa, the Provider or Facility shall comply with BCBSGa’s requests to submit complete and accurate medical records, Encounter Facilitation Forms or other similar encounter or risk adjustment data in a timely manner to BCBSGa, Plan or designee upon request.
In addition to the above ACA related commercial risk adjustment requirements, Providers and Facilities also may be required to produce certain documentation for Covered Individuals enrolled in Medicare Advantage or Medicaid.

**RADV Audits**

As part of the risk adjustment process, HHS will perform a risk adjustment data validation (RADV) audit in order to validate the Covered Individuals’ diagnosis data that was previously submitted by health plans. These audits are typically performed once a year. If the health plan is selected by HHS to participate in a RADV audit, the health plan and the Providers or Facilities that treated the Covered Individuals included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

**ICD-10 CM Codes**

HHS requires that physicians use the ICD-10 CM Codes (ICD-10 Codes) or successor codes and coding practices services under ACA Compliant Plans... In all cases, the medical record documentation must support the ICD-10 Codes or successor codes selected and substantiate that proper coding guidelines were followed by the Provider or Facility. For example, in accordance with the guidelines, it is important for Providers and Facilities to code all conditions that co-exist at the time of an encounter and that require or affect patient care, treatment or management. In addition, coding guidelines require that the Provider or Facility code to the highest level of specificity which includes fully documenting the patient’s diagnosis.

**Medical Record Documentation Requirements**

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code or successor code is assigned; and
- They are used to validate diagnosis data that was previously provided to HHS by the health plans.

Because of this, the Provider and Facility play an extremely important role in ensuring that the best documentation practices are established.

HHS record documentation requirements include:

- Patient’s name and date of birth should appear on all pages of record.
- Patient’s condition(s) should be clearly documented in record.
- The documentation must show that the condition was monitored, evaluated, assessed/addressed or treated (MEAT), or there is evidence of treatment, assessment, monitoring or medicate, plan, evaluate, referral (TAMPER).
- The documentation describing the condition and MEAT or TAMPER must be legible.
- The documentation must be clear, concise, complete and specific.
- When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.
- Physician’s/Qualified Non-Physician’s signature, credentials and date must appear on record and must be legible.

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**Gatekeeper HMO Specific Guidelines**

**Role of the Primary Care Physician**
The primary care physician ("PCP") is responsible for providing care within the scope of his or her practice and managing all other aspects of the member’s medical care. This includes coordinating notifications for Covered Individual referrals to specialists and obtaining pre-authorizations for hospital admissions. PCPs also confer with specialists about admissions recommended by a specialist.

For BlueChoice HMO/Blue Choice Option Covered Individuals, the PCP will coordinate referrals for specialty care and inpatient admissions, either directly or in collaboration with a specialist.

Specifically, the PCP will:

- Serve as the Covered Individual’s personal physician, providing services and treatment without discrimination
- Provide all primary care services in a manner consistent with customary and recognized standards
- Coordinate and manage all other medical services
- Notify BCBSGA about referrals to in-network specialists
- Obtain pre-authorizations for inpatient admissions
- Obtain pre-authorizations for outpatient procedures
- Refer and admit only within the BCBSGA network
- Comply with required BCBSGA procedures
- Accept BCBSGA reimbursement
- Provide 24-hour, 7-day a week access to medical care for Covered Individuals

For BlueChoice HMO, BlueChoice Option ("POS") Individuals, PCPs should follow these procedures for office services:

- Verify Covered Individual eligibility and PCP assignment (via www.availity.com)
- Provide care
- Collect co-payment
- File CMS 1500 Claim form

NOTE: Nothing in this manual is intended to supersede or substitute for the PCP’s judgment about what is in the Covered Individual’s best medical interest.

 Covered Individual Selection of a PCP

When a Covered Individual enrolls in the BlueChoice HMO or BlueChoice Option, he or she will select a PCP from our provider Network. PCPs are notified monthly of new patients for whom they are responsible. Covered Individuals may change their PCP by notifying BCBSGA and changes become effective on the first day of the following month if the change is received by the 25th of the month. If the change occurs after the 25th, it will be effective on the first day of the subsequent month.

 PCP Scope of Services

At BCBSGA, we want to ensure that our Covered Individuals receive continuous, appropriate health care in accordance with the physician’s network participation agreement. We also want to ensure that each PCP has the generally acceptable skills necessary to care for common primary care medical conditions. Accordingly, we require our network physicians to meet and comply with the following criteria in their scope of practice.

The PCP will coordinate all aspects of Covered Individuals’ care, including generating referrals to network specialists and plan notification for POS Covered Individuals.

The PCP will coordinate, monitor and ensure the continuity of a Covered Individual’s care after a referral is approved.

The PCP will seek prior authorization for non-participating provider referrals, except in an emergency. This includes out-of-network specialists, ancillary and facility providers.

The PCP will use designated laboratory, radiology, specialist physicians, ancillary and facility provider networks as outlined in this manual or designated local region communications.
The PCP will comply with the BCBSGA quality assurance and utilization management initiatives and related policies and procedures.

These include:

- Requesting practice closure to new Covered Individuals as stated above and providing written notification to BCBSGA at least 90 calendar days in advance of the anticipated closure;
- Reporting all patient encounters, including all applicable diagnosis (ICD-10 or successor codes) and procedure (CPT IV) codes;
- Collecting Covered Individual copayments at each visit;
- Acknowledging the PCP of record is responsible for a Covered Individual’s care (including emergency care) even if the Covered Individual has not been treated in the office;
- Cooperating with medical record and site survey processes;
- Obtaining prior authorization for inpatient medical admissions, except emergencies;
- Providing 24-hour, 7-day per week access to primary care services – or providing a covering physician. (Covered Individuals should go to the emergency room only if an emergency condition exists. Use of urgent care centers will be based on BCBSGA’s policy and referral requirements.)
- Prescribing generic equivalent drugs when possible and using the Preferred Drug List when applicable (see www.bcbsga.com);
- Accepting reimbursement as detailed in the PCP network participation agreement.

The PCP will provide comprehensive, continuous medical and preventive care appropriate to the age range of the practice’s specialty.

This care will include, but not be limited to:

- Newborn care, including hospital-based
- Infant care
- Children’s care
- Adolescent care
- Adult care
- Elderly care
- Periodic health assessment and physical exams in accordance with the established Preventive Health Guidelines, including interventions, immunizations and screenings
- Patient education and counseling
- Health promotion counseling, including injury prevention
- Well-woman exams
- Family planning
- Nutrition counseling
- Drug and tobacco counseling
- Cancer screening
- Screening for heart disease
- Emergency and urgent care triage
- Ambulatory, hospital and home care
  Note: A PCP may coordinate inpatient hospital care through an in-network hospitalist.
- Nursing home and hospice care
- Treatment for acute illness, including:
  - Musculoskeletal (fibromyalgia, tendonitis, etc.)
  - ENT (sinusitis, otitis media, etc.)
  - Ophthalmic (corneal abrasion, conjunctivitis, etc.)
  - Dermatologic (scabies, pediculosis, etc.)
  - Infectious (cellulitis, pneumonia, etc.)
  - Gynecological (vaginitis, etc.)
  - Urologic (urinary tract infection, etc.)
  - Gastrointestinal
  - Cardiovascular
  - Neurological
  - Pulmonary
- Treatment for chronic illnesses, including:
- Cardiovascular (angina, hypertension, stroke, etc.)
- Endocrine (diabetes, thyroid disease, etc.)
- Musculoskeletal (rheumatoid arthritis, osteoarthritis, etc.)
- Pulmonary (asthma, bronchitis, emphysema, etc.)
- Skin (acne, dermatitis, etc.)
- Gastrointestinal (ulcer, irritable bowel, etc.)
- Genitourinary (urinary incontinence, etc.)
- Identifying and recommending treatment for depression, anxiety disorders, stress, grief reaction
- Identifying and recommending treatment for substance abuse
- Comprehensive assessment
- Evaluation of occupational and school health-related illnesses
- Death and dying counseling
- Knowledge about interdisciplinary resources and Community and public health resources
- Managed care practice management, including cost-effective care and appropriate use of consultants
- Risk management

The PCP will provide for or coordinate the following in-network or approved out-of-network interventions in the appropriate ambulatory setting:

- EKGs
- Routine sigmoidoscopy
- Injections and immunizations
- Allergen immunotherapy injections
- Vision and hearing screening
- Routine lab work (UA, FBS, Hct, rapid strep, etc.)
- Radiology
- 24-hour holter monitor
- Minor surgery, including laceration repair

**Missed Physician Appointments**

To receive reimbursement when a Covered Individual misses a set appointment time, the PCP must first establish a written office policy addressing payment for missed appointments. Covered Individuals should acknowledge their understanding of the policy in writing. Normally this can be accomplished with a one-time signature. Once the policy has been established and the Covered Individual has signed his or her acknowledgement, the follow guidelines apply:

- A PCP shall not collect a missed appointment fee unless the Covered Individual has signed a statement acknowledging understanding of the policy.
- Claim forms for missed appointments should not be submitted.
- PCPs are encouraged to accept the Covered Individual’s co-pay as the fee for missed appointments.
- PCPs should report repeated missed appointments to Customer Service in order for Covered Individuals to be effectively educated.
- If the Covered Individual continues to miss appointments and does not pay for them, the PCP has the right to request that the Covered Individual be removed from his or her patient list. (Please refer to: Terminating a physician-patient relationship.)

**Terminating a Physician-Patient Relationship**

A PCP may request that a Covered Individual be removed from his or her patient list. Covered Individuals selecting a PCP are responsible for making a positive contribution to the physician-patient relationship. If an effective physician-patient relationship cannot be established, the PCP may discharge a Covered Individual from his or her care.

After receiving approval to terminate the relationship, the PCP must:

- Provide written notice via Certified Mail to the Covered Individual explaining the intention to discharge the Covered Individual from his or her patient list.
- Advise the Covered Individual to select another PCP. The Covered Individual may log on to www.bcbsga.com or contact BCBSGa’s customer service department to select another PCP.
- Send a copy of the notice to BCBSGa provider representative.
- For thirty (30) calendar days, the PCP is required to provide health care services to the Covered Individual until the Covered Individual has selected another PCP.

Access Standards

BCBSGa has developed the following standards to ensure that our Covered Individuals have timely access to medical care:

Office hours

A physician’s office must be open at least four (4) days per week. If a PCP has more than one office, he or she must be available to BCBSGa Covered Individuals a total of four (4) days per week. The PCP must directly provide at least twenty (20) hours of in-office patient care per week. If he or she has more than one (1) office, the PCP must be available to BCBSGa Covered Individuals for a total of twenty (20) hours per week.

Appointment availability

- An appointment for a periodic health assessment for preventive care must be scheduled within sixty (60) calendar days of a Covered Individual’s initial call or ninety (90) days for OB/GYN.
- An appointment for a routine office visit (such as follow-up, blood pressure and weight checks, prescription refills, etc.) must be scheduled within fourteen (14) days of a Covered Individual’s initial call – or within thirty (30) days for OB/GYN – or ten (10) business days for Behavioral Health.
- For emergent diagnoses, PCPs must provide same-day appointments. Behavioral Health providers must be available to assess a patient experiencing an emergent situation within six (6) hours.
- For urgent diagnoses, appointments must be available within twenty-four (24) hours. Behavioral Health providers must be available to assess a patient experiencing an urgent situation within forty-eight (48) hours.
- Same-day appointments must be available depending on the urgency of the Covered Individual’s complaint.

After hours coverage

- Twenty-four (24) hours/seven (7) days a week on call coverage
- Physician to call back within two (2) hours
- Covering physicians must be BCBSGa network physicians
- On-Call physician should provide triage for urgent/emergency care

Office wait time

Office wait time for a scheduled appointment is thirty (30) minutes or less. If the wait time will likely be more than thirty (30) minutes, the Covered Individual has a choice of waiting or rescheduling the appointment.

Telephone access

- Incoming phone calls to the provider’s office must be answered within ten (10) rings
- Office staff should ask permission to place callers on hold before doing so. If a caller is placed on hold, the call will be acknowledged every two minutes.
- The physician must provide coverage twenty-four (24) hours, seven (7) days-a-week for appropriate triage.

Role of the Specialty Care Physician

BCBSGa PCPs refer Covered Individuals of BCBSGa to specialists who participate in the BCBSGa Network*. Except in emergency situations, Covered Individuals’ specialty care must be coordinated through their PCP.
PCPs are required to refer Covered Individuals only to HMO participating specialists. These specialists work with the Covered Individual’s PCP and recognize the PCP’s role as manager of all the Covered Individual’s medical care. Covered Individuals covered under a Point-of-Service (‘POS’) plan have benefits available for out-of-network services.

*Note: A referral from a PCP is not required for Behavioral Health Services. Covered Individuals may self-refer by calling the telephone number on their Covered Individual identification card. HMO and Point-of-Service Covered Individuals do not have out-of-network benefits for Behavioral Health Services and must obtain services from a Participating Provider.

Responsibilities of the Specialist

After confirming that the PCP has notified BCBSGa of the referral, the specialist’s responsibilities include:

- Confirm a valid referral has been obtained from the PCP (when required) before rendering services to BCBSGa Covered Individuals
- Providing appropriate, necessary medical services to the BCBSGa Covered Individual
- Communicating findings and recommended treatment to the PCP in a timely manner
- Consulting with the Covered Individual’s PCP before recommending further specialty care or referring the Covered Individual to another specialist
- Complying with Utilization Management and Quality Assurance programs as required by BCBSGa
- Obtaining prior authorization for all hospital admissions, with concurrence of the PCP
- Accepting the Covered Individual’s BlueChoice ID card and co-payment in lieu of full payment at the time of service
- Filing Claims for services to Covered Individuals, using the CMS 1500 form
- Accepting reimbursement as payment in full from BCBSGa as specified in the Agreement as payment in full from BCBSGa.
- Billing BCBSGa Covered Individuals only for applicable Cost Shares

Specialist Physician Guide

Specialists should use the following guidelines when providing services to BlueChoice Covered Individuals:

Verify Covered Individual eligibility

- Check the Covered Individual’s ID card
- Verify eligibility online at www.availity.com or
- Call BCBSGa for confirmation of coverage and benefits

Ensure proper referral

- Verify the referral has been obtained via online at www.availity.com.
- If a referral notification cannot be confirmed, inform the Covered Individual that he or she may be responsible for all or part of the bill for the specialist’s services. The specialist may then contact the PCP, or direct the Covered Individual to seek referral notification through the PCP and BCBSGa.
- Secure authorization from the PCP for additional consultations or services beyond what was initially authorized for a specific condition.

Direct Access Specialists

Ophthalmology, Optometry, OB/GYN, and Dermatology are considered direct access specialties to which Covered Individuals are entitled to refer themselves to in-network specialists. (No referral from the PCP is necessary.) Covered services are limited to those associated with each provider specialty and are subject to BCBSGa utilization management guidelines.

PCP referral is not required for a Covered Individual to access outpatient or inpatient mental health and substance abuse services. The Covered Individual Health Benefit plan requires that Providers render services. Behavioral health providers are strongly encouraged to provide PCPs with updates regarding treatment progress and medication usage.
Specialist to Specialist Referral

Specialists may refer patient to other specialists for Covered Services only in the following circumstances:

- OB/GYNs may refer to:
  - any in-network specialist if the Covered Individual is pregnant
  - in-network general surgeon or interventional radiologist for breast mass
  - in-network GYN-Oncologist or Infertility Specialist
- Orthopedists/Neurologists/Neurosurgeons and Rheumatologists may refer to physical therapy.
- Orthopedists may refer to Neurologist for nerve conduction studies (testing only).
- Orthopedists may refer to Physical Medicine and Rehabilitation specialists.
- Specialists may refer Covered Individual for diagnostic testing, additional visits, and inpatient and outpatient admission after consulting with PCP.

All other referrals must be submitted by the PCP.

Please note: The ordering physician is responsible for the approval of tests that require precertification or notification.

Self-Referrals by Covered Individuals

BlueChoice Option (POS) Covered Individuals may self-refer to any in-network or out-of-network provider and receive services at a significantly reduced benefit level, except in the following cases:

- Preventive Care is covered only if performed by the Covered Individual's PCP (except mammogram, Pap smear, prostate antigen test, and child wellness from birth through age five).
- Behavioral Health Services (Mental Health and Substance Abuse) are not covered if rendered by an out-of-network provider.
- Non-emergency use of the emergency room is not covered.

BlueChoice Option Covered Individuals must use Provider s for all services to receive in-network benefits. However, they may also self-refer to an out-of-network specialist (for services not listed above) and be subject to a reduced out-of-network benefit level.

BlueChoice HMO Covered Individuals may self-refer to the following specialists:

- OB/GYNs for annual well-woman exam and any OB/GYN-related medical conditions including pregnancy termination.
- Dermatologist for any related medical conditions.
- Optometrist/Ophthalmologist for consultation of medical conditions of the eyes.
- Behavioral Health providers for Mental Health and Substance Abuse services.
- Oral Surgeons for impacted wisdom teeth.

BlueChoice HMO Covered Individuals must use Network Providers to receive benefits for these services.

OB/GYN Specific Information

Well Woman Exams

BlueChoice HMO/BlueChoice Option provides coverage for one routine gynecological examination per contract year for all women Covered Individuals pending group benefit specifics.

By the Covered Individual’s choice, the well woman examination may be performed by either the Covered Individual’s PCP or a participating Obstetrician or Gynecologist.
Provider s are to bill for well woman services using any office CPT code listed below and the ICD-10 or successor codes V72.3 in any of the diagnostic fields on the professional Claim form.

Office/Preventive Visit: 99201-99215, 99384-99387, 99394-99397

BlueChoice HMO/BlueChoice Option benefits cover only the services listed below, depending on group-specific benefit levels, when part of the well woman examination:

- Medical/Gynecologic history of the Covered Individual
- Physician examination of the breast and pelvic organs
- Pap smear through contracted ancillary laboratory (LabCorp)
- Microscopic examination of the vaginal smear through contract ancillary laboratory (LabCorp)
- Treatment of incidental vaginal infections (i.e. yeast, trichomonas, and non-specified infections)
- Rectal examination after age 40 years
- Birth Control administration
- Urinalysis (through LabCorp)
- Hematocrit (through LabCorp)

**Mammogram**

Initial screening between 35-40 years of age and then every one to two years between ages 40-50. Women over age 50 should have an annual mammogram. Mammograms may be done in a physician’s office if the office is ACR accredited. Physicians who perform mammograms in their office are asked to bill a global fee. The office will be responsible for any reading or interpretation fees associated with the mammogram.

**Contraceptive Management**

- Norplant removal
- Depo-Provera (per 150 mg. Injection)
- IUD insertion
- IUD removal
- IUD contraceptive device
- Fitting of diaphragm/cap

**Obstetrics Care**

Vaginal or C-Section delivery global fee includes the following:

- Comprehensive first visit
- All visits related to obstetrical care
- Non-stress test (times two)*
- Ultrasound
- Lab work will be capitated
- Delivery: Vaginal or C-section
- Postpartum care (up to 8 weeks)

* The global fee will be reduced for offices that do not do ultrasounds or non-stress tests.

**High Risk Obstetrics Cases**

- Gestational diabetes
- Pregnancy induced hypertension
- Pre-existing chronic illnesses such as SLE, renal disease, etc.
- Congenital anomalies affecting delivery or requiring immediate intervention
- Intrauterine fetal growth retardation

*Includes all non-stress tests to be done.*

**Miscarriage and Early Fetal Demise:**
Will be reimbursed as fee-for-service

Past Twenty (20) Weeks:

- Global fee will be paid

Referral and Preauthorization

- Please notify the Utilization Management Department of the Covered Individual’s pregnancy. Precertification is not required for vaginal and C-section deliveries that do not exceed the mandated two (2) day or four (4) day inpatient stay. Any length of stay beyond those timeframes for vaginal (2 days) and C-section (4 days) deliveries must be precertified by the Utilization Management Department.

Surgical Assistants at C-Sections

There has been much confusion over the terms Surgical Assistant versus Assistant Surgeons as they relate to C-sections. After careful review and input from both external consultants and local OB/GYNs, we have now clarified the definition and reimbursement for these services. Please take a moment to review the following so that we all have the same understanding.

Surgical Assistant: A technically skilled professional (not required to be MD) to assist during a surgical procedure.

Assistant Surgeon: A licensed physician. Assistant surgeons are approved and reimbursed based on the medical necessity for an assistant surgeon during this procedure.

Group Specific Benefits

Please verify Covered Individual benefits to determine if there are group specific benefits for the employer group.

Emergency services

- Contact the PCP, if practical
- If the situation is a true emergency, treat the patient, then contact his or her PCP
- Contact the PCP and BCBSGa within 24 hours of emergency admissions

File Claims for Covered Individuals

- Mail Claims to address on back of Covered Individual ID Card
- Submit CMS 1500 to BCBSGa
- Accept BCBSGa reimbursement
- Collect deductible, co-insurance and co-payments from the Covered Individual

Covering Physician(s)

The PCP must be available and accessible to provide or coordinate all health care services for Covered Individuals (including but not limited to emergency medical care, outpatient services and inpatient hospital services) twenty-four (24) hours per day, seven (7) days per week, either directly or through an appropriate call system providing for timely callback. In the event the PCP cannot provide these services personally, the call coverage must be provided through another Network physician (“Covering Physician”).

PCPs are reimbursed either on a monthly capitation fee or fee for service basis to provide health care services to Covered Individuals. When the capitated PCP arranges for a Covering Physician, who is also reimbursed on a capitation basis, to provide call coverage, the PCP is responsible for making arrangements to pay the Covering Physician. The Covering Physician may not bill BCBSGa for any health care services which are covered under the capitation fee because BCBSGa has already paid the PCP to provide those services. When a fee for service PCP arranges for a Covering Physician, who is also reimbursed on a fee for service basis, to provide call coverage BCBSGa will reimburse the Covering Physician according to the applicable fee schedule. The PCP is also responsible for ensuring that the Covering Physician (i) only bills a Covered
Individual for (A) non-Covered Services which Covered Individual agrees to in writing BEFORE such services are provided, and (B) all applicable cost share amounts applicable to the Covered Services, and (ii) does not bill a Covered Individual for the difference between the Covering Physician’s charges and the amount of compensation paid to the Covering Physician by the PCP (i.e., no balance billing).

**Covered Individual Copayment**

BCBSGa Covered Individuals are only responsible for a copayment amount for Covered Services provided by the PCP in his/her office. The copayment is printed on the Covered Individual’s ID card.

A physician copayment may be collected for any visit at which a physician or healthcare professional sees a Covered Individual and an office visit CPT procedure code is filed on the Claim. The copayment should not be collected if the Covered Individual is only assisted by the administrative staff (examples: picking up a prescription or requisition or drawing for laboratory tests).

Group benefits may supersede the copayment allocation. Please verify BCBSGa Covered Individual eligibility and benefits to determine the appropriate collection of the Covered Individual's copayment.

Please note: Only one copayment may be collected for each patient visit. An additional copayment may be applicable for urgent care visits. Group specific benefit inclusions and/or exclusions will supersede BCBSGa standard Health Benefit plan structure. Copayment for flu vaccines is dependent on the Covered Individual’s benefits as outlined in their Covered Individual Certificate Booklet. Please verify Covered Individual eligibility and benefits to determine appropriate collection of Covered Individual copayment.

**PCPs Reimbursement**

PCPs are reimbursed either on a fee-for-service or capitation basis, in accordance with his/her BCBSGa PCP Agreement. Those PCPs who are reimbursed according to a capitation schedule receive a monthly payment equal to the capitation rate multiplied by the number of BCBSGa Covered Individuals assigned to the practice. In addition to that monthly capitation payment, some procedures are separately paid on a fee-for-service basis.

Capitation payments are made on a full month basis only, and are never prorated. Covered Individual effective dates of eligibility and PCP changes are, therefore, normally the 1st of the month. Covered Individuals may be added or cancelled up to sixty days retroactively.

In some cases Covered Individuals will become effective on dates other than the first of the month (e.g. newborns). Capitation for Covered Individuals with mid-month effective dates will be paid as follows:

<table>
<thead>
<tr>
<th>Effective Date of Enrollment</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st through 15th</td>
<td>Full capitation for month</td>
</tr>
<tr>
<td>16th through 31st</td>
<td>No capitation for first month</td>
</tr>
</tbody>
</table>

Also, Covered Individuals may terminate coverage during the month (e.g. they terminate employment with the group who insures them). Capitation for Covered Individuals with mid-month termination dates will be paid as follows:

<table>
<thead>
<tr>
<th>Effective Date of Termination</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st through 15th</td>
<td>No capitation for final month</td>
</tr>
<tr>
<td>16th through 31st</td>
<td>Full capitation for month</td>
</tr>
</tbody>
</table>

**Encounter Reporting**

All services provided to BCBSGa Covered Individuals must be reported in the standard HIPAA compliant Claim format using HIPAA-compliant code sets on the CMS-1500 Claim form or the equivalent, within the filing standards timeframe, and with applicable charges noted. This is necessary for reporting of utilization data and HEDIS purposes. The Claim system will identify CPT codes eligible for fee-for-service payment and will approve those services when appropriate.
Please remember to verify the Covered Individual’s ID card on each visit to ensure your Claims are submitted with the correct Covered Individual ID for that particular date of service. Electronic Claim submission still remains the most efficient way to submit your Claims; however, if you submit a hard copy Claim please refer to the back of the Covered Individual’s ID card for the appropriate Claim submission address and customer service number.

**Discontinuing Acceptance of New Patients**

According to their contractual agreement, PCPs are required to accept BlueChoice HMO or BlueChoice Option Covered Individuals who select them as their PCP up to the practical limit set by their practice. As long as the physician’s practice is generally open to new patients, he or she must be available for PCP selection by Covered Individuals.

PCPs may close their practice to BlueChoice HMO and BlueChoice Option Covered Individuals only if the practice is also closed to all new patients. To close the practice to new patients, PCPs must give 90 (ninety) days advance written notice to BCBSGa. The ninety (90)-day notice begins on the date BCBSGa receives a written document indicating the physician’s intent to close the practice. The effective date will be the 91st day following receipt of the notice. PCPs must continue to accept new patients during the ninety (90)-day notice period.

Even if a physician’s practice is closed to new patients, he or she must accept existing patients who convert coverage from another carrier to BlueChoice HMO or BlueChoice Option and choose the physician as their PCP.

When BCBSGa receives written notification that a physician’s practice is closed to new patients, that information will be posted in the managed care system and at bcbsga.com. When the physician or physician’s group is once again accepting new patients, the system will be updated and bcbsga.com.

Please send the written notice about closing or reopening a physician practice to your provider network representative.

**Changes to Practice**

Adding new physicians to the practice group – Participating PCPs shall provide BCBSGa with thirty (30) days prior written notice when their group adds or deletes physicians. New physicians joining a participating practice must submit a completed application along with contract documents. They must also meet all credentialing criteria required by BCBSGa to become a Covered Individual of the network.

Changing participation status – PCPs who wish to withdraw from the network must notify BCBSGa in writing one hundred twenty (120) calendar days before the cancellation of the contract. The one hundred twenty (120) day period will begin on the date BCBSGa receives the written notice. Changes involving adding or discontinuing physicians from a practice, or changing participation status must be sent in writing to your local provider representative. Physicians contracted through Quality Care Providers, Inc. (“QCPI”) should refer to Appendix A of this manual for notification requirements.

**Covered Individuals and Enrollment**

**Enrollment Procedures**

New BlueChoice Covered Individuals must select a PCP from the panel of Providers. PCPs are physicians those who practice internal medicine, general practice, family practice, or pediatrics. Covered Individuals must complete enrollment forms for themselves and all dependents. Each Covered Individual covered by the contract may choose a different PCP within the network. BCBSGa will notify the physician of his or her selection as a Covered Individual’s PCP. Covered Individuals may change PCPs by logging on to our website www.bcbsga.com or by calling BCBSGa customer service. PCP changes requested by the 25th of the month are effective the first day of the following month.

Physicians, who have questions about enrollment, Covered Individual eligibility, or information appearing on his or her monthly Covered Individual list, may verify this information at avality.com.
PCP Practice Age Restrictions

The age range of patients seen by a PCP will be set as follows unless otherwise requested by the physician:

- **Family Practice**: No restriction/will see patients of any age
- **Internal Medicine**: Fifteen (15) years and older
- **Pediatrician**: Newborn through age twenty (20) years

The PCP can establish age limitations for his/her practice, as long as those age limitations are applied equally to all managed care plans accepted by the PCP and adhere to the following standards:

- A Pediatrician is not to see an adult Covered Individual age twenty-one (21) years or older
- An Internal Medicine physician is not to see a child age fourteen (14) years or younger unless the physician has been approved by the BCBSGa Medical Director to see this age group.

Covered Individual Identification and Eligibility

Each BlueChoice Covered Individual has an ID card that shows the Covered Individual’s contract number and basic coverage information, including office visit co-payment. We urge physicians to keep a copy of the Covered Individual’s ID card in the patient’s office file and to verify Covered Individuals and eligibility periodically.

Presenting a Covered Individual ID card does not guarantee eligibility, since Covered Individuals may cancel their coverage at any time. Eligibility for benefits is determined by the Covered Individual’s coverage status at the time of service.

When a BlueChoice Covered Individual arrives at the physician’s office, he or she should present his/her Covered Individual ID card upon check in. Office staff should verify the PCP selection by checking the monthly Covered Individuals list. If the Covered Individual seeks service before he or she has received a Covered Individual ID card, or before appearing on the monthly Covered Individual list, the office staff may verify coverage at avility.com.

The office visit co-pay amount is listed on the front of the Covered Individual ID card. Co-payments may vary depending on the Covered Individual’s Health Benefit Plan. Covered Individuals should pay the indicated amount for each office visit.

If a BlueChoice Covered Individual seeks service from a PCP who is not that Covered Individual’s designated physician, the office staff should verify the Covered Individual’s PCP by checking www.bcbsga.com or by calling the Provider Customer Service Information Line. The Covered Individual should then be directed to the correct PCP’s office. If the Covered Individual resists going to the designated PCP, he or she must understand that benefits either will not be available or they will be reduced to out-of-Network levels.

Directory of Services

Quick Reference Guide

Blue Cross and Blue Shield of Georgia website: bcbsga.com

Providers and their staffs have fast, easy access to claim status information twenty-four (24) hours a day, seven (7) days a week through our website.

Network Management (Provider engagement and contracting)

*Provider relations* - Contact provider relations for:

- General questions
- New provider enrollment inquiries

Telephone: Toll-free: 888-706-3475; Fax #: 877-551-6184
**E-mail:** Contact your local provider Representative

**Provider change requests**

Change requests must be submitted using the BCBSGa Provider Maintenance Form (formerly known as PIC form).
To access the form visit bcbsga.com > Provider Forms > Provider Maintenance Form.

**Credentialing inquiries**

For Provider credentialing and re-credentialing status inquiries contact your BCBSGa credentialing customer service team:

- **Telephone:** 800-516-7587
- **Fax #:** 800-848-7347
- **Email:** you must call and request the email address

*For credentialing assistance contact the Council for Affordable Quality Healthcare (CAQH):*
E-mail: help@updadmin.acsgs.com Telephone: 888-599-1771 (Help Desk hours: 6 a.m. – 8 p.m. CT). Please have your CAQH Provider ID available when you call.

*If you have already started the CAQH application process, please be sure your application is complete and all of the necessary supporting documents have been submitted via fax, toll-free, to CAQH at 866-293-1414. Please be sure to select BCBSGa as a Healthcare Organization authorized to access your information.*

**Request fee schedule**

Please send requests in one of two ways:

- **E-mail:** Contact your local Provider Representative
- **Fax:** 877-551-6184

BCBSGa will respond to your request within five business days by e-mail.

**Provider appeals**

Providers may initiate a complaint by sending documentation, including a cover letter outlining the issue. If the complaint is 10 pages or less, the complaint can be faxed to: 888-859-3046. For longer documents, the complaint can be mailed to:

BCBSGa, Attn: Provider Appeals

GA Local PO Box for appeals:
PO Box 105449
Atlanta GA 30348-5449

**Clear Claim Connection™**

This online tool enables providers to pre-screen proposed coding and understand reimbursement policies that apply to their Claims. Login to our secured BCBSGa provider website, bcbsga.com, and select the Clear Claim Connection option.

**Web support**

Need assistance with BCBSGa ProviderAccess?
Contact the BCBSGa Web Support Unit online at Websupport@bcbsga.com or call 866-755-2680.

**Electronic Claims filing assistance**

The Electronic Data Interchange (EDI) Solutions Helpdesk is available Mon. – Fri., 8:00 a.m. – 4:30 p.m. EST for assistance with electronic Claims filing:

- **E-mail:** e-solutions.support@bcbsga.com
- **Telephone:** 800-470-9630
Clinical guidelines

As part of our commitment to providing the latest clinical information and educational materials, we’ve adopted nationally recognized clinical guidelines. You can view them online at: bcbsga.com by clicking on Medical Policy and Clinical UM Guidelines on the left side of the page. Or, if you would like a paper copy mailed to you, contact the BCBSGa Clinical Quality Representatives at 800-545-0948 ext. 6171.

Interplan Teleprocessing Services (ITS)

Telephone: 800-628-3988 Fax #: 877-868-7950 Medical records fax #: 706-494-8603 Mail: Interplan Teleprocessing Services, P.O. BOX 105187, Atlanta, GA 30348

AIM provider website

Real-time imaging requests and inquiries can be addressed 24 hours a day, 7 days a week, 365 days a year when you visit American Imaging Management (AIM) online at www.americanimaging.net. You can also reach AIM as follows:
- For pre-authorization: call 866-714-1103
- For customer service via e-mail: WebCustomerService@americanimaging.net
- For customer service by phone: 800-252-2021

BCBSGa automated customer care information line

Call the toll free number on the back of the Covered Individual’s ID card. Our automated telephone voice response unit is available 24/7 to verify:
- Covered Individual eligibility
- Benefits
- Coverage status
- Primary care physician (PCP)
Menu options direct callers to the correct department.

BCBSGa departmental customer care lines

- Facility Customer Care: 800-284-2609
- Professional Customer Care: 800-241-7475
- ITS Customer Care: 800-628-3988
- BlueCard Eligibility: 800-676-2583
- HMO USA Away From Home Care Guest Membership: 800-535-8291

BCBSGa PCP Referral Process

To obtain a referral to a specialty care provider, PCPs should follow the guidelines below when referring Covered Individuals to a BCBSGa contracted specialty care provider:
- Submit requests/notifications online: availity.com
- Submit requests by telephone: 800-662-9023 or 800-722-6614
- Fax requests to 404-467-2999 (for HMO Covered Individuals); 404-848-2384 (for POS Covered Individuals)
A referral number is not necessary and will not be supplied. Referrals are notification only. Submit all notifications of referrals prior to the Covered Individual receiving services from specialists. Retrospective requests for non-emergency specialist referrals will result in delays and/or denials in Claim payment.

BCBSGa Utilization Management (UM) services

E-Review allows providers to send information to, and receive information from BCBSGa about clinical review requests via secure e-mail.
To send a secure email go to bcbsga.com > enter Medical Policy and Clinical UM Guidelines (on left) > Continue > click on email address at bottom of the page
BCBSGa will continue to address phone, fax and mail requests for review and decision notification.
☐ Telephone: 800-662-9023 or 800-722-6614. Urgent inbound communication can be received 24 hours a day 7 days a week
☐ Fax #: 877-254-4971
☐ Mail: 2357 Warm Springs Road Columbus, Georgia 31904
Specialty pharmacy predetermination requests are available through AIM’s provider website at: https://www.providerportal.com or via fax at 404-848-2448.

Federal Employee Program (FEHBP)
Case management inquiries can be made by:
☐ Telephone: 800-711-2225
☐ Fax: 800-732-8318
Pre-certifications and UM service inquiries can be made by:
☐ Telephone: 800-860-2156
☐ Fax: 800-732-8318

Claims mailing address
Refer to the back of the Covered Individual’s ID card for the appropriate Claims mailing address.
Availity®, multi-payer web portal
Website: availity.com
BCBSGa has collaborated with Availity®, one of the nation’s leading health information networks, to deliver a multi-payer portal to Providers in Georgia. Availity offers a wide variety of online tools that allow providers to access real-time information from multiple payers via one secure sign-on including eligibility and benefits and Claim status information. Go to the Provider home page at bcbsga.com for more information.

CAPITATED SPECIALTY NETWORK ADMINISTRATION - ATLANTA AREA ONLY
BlueChoice HMO and BlueChoice Option only

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<th>Network Name</th>
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<tr>
<td>Allergy</td>
<td>Atlanta Allergy &amp; Asthma Clinic</td>
<td>BCBSGa</td>
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<td></td>
<td>1965 North Park Place, NW Suite 540</td>
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<td>David Tanner, MD – Medical Director</td>
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Neurosurgery & Georgia Neurosurgical Affiliates & BCBSGa \\
1117 Perimeter Center West & 105187 & Claims: \\
Suite W213 & Atlanta, GA 30338 & PO Box 105187 \\
Atlanta, GA 30338 & Atlanta, GA 30348 & \\
Administrator: Howard Fagin & Correspondence: \\
Medical Directors: & BCBSGa \\
Michael Goodman, MD & Mail Code: GAG006-0010 \\
H. Dale Richardson, MD & 3350 Peachtree Road, NE \\
& Atlanta, GA 30326 \\
& 888-708-3475 \\
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BlueCard / ITS Program

* The BlueCard/ITS program enable Georgia providers to submit Claims for Covered Individuals of other Blue Cross and Blue Shield plans to BCBSGa. The three character alpha prefix at the beginning of the Covered Individual’s ID number is the key data element used by BCBSGa to identify ITS Claims.

** BCBSGa provides UM and Network services only for this Plan.

Provider Contracting and Provider Relations

In order to meet the service needs of the our Provider s, we have assembled an experienced staff (consisting of Provider Network Managers, Network Management Consultants, Network Management Representatives and administrative support associates) who are available to assist you. They have access to email and voicemail in the event you are not able to reach them by telephone.

The Provider Network Managers generally serve as the primary contacts for contractual issues and questions.

The Network Management Consultants (“NMCs”) generally serve as provider liaisons and are responsible for physician recruitment, on-site orientation, on-going training, and policy and procedure consultations.

The Network Management Representatives (“NMRs) can answer questions regarding Network development and training. They will assist you with questions regarding administrative policy and procedures, problem resolution and service needs (including practice changes, etc.). These associates are also responsible for researching and resolving Covered Individual complaints, capitation payment issues, and provider grievances and appeals.

Provider Access

Provider Access®

Providers and Facilities have fast, easy access to information about Covered Individuals and Claims – twenty-four (24) hours a day, seven (7) days a week. Simply log on to www.bcbsga.com and click on the Login button for Provider Access. A password is required to access the online tool and you can register for a user ID and password online. You will receive your password in the mail within seven (7) to fourteen (14) days. Provider Access is the total information source for:

Remits*

- CPT code and contract type
- Immediate printout of a specific remit

Clear Claim Connection*


• A tool that allows Providers to view current clinically based information along with documented source information for edits. Sources referenced include: the American Medical Association Current Procedural Terminology ("CPT"), the CPT Assistant, the CPT Coding Symposium, Specialty Society Coding Guidelines and Medicare Guidelines. Clear Claim Connection will provide information according to the Claim editing system logic on the date of the provider’s inquiry. Clear Claim Connection is not date sensitive for the Claim date of service.

*Remits and Clear Claim Connection results can still be found on Provider Access at this time; however the change to move remittance solely to Availity will be coming.

Blue Exchange

You can no longer access information about coverage and claims on Provider Access. Eligibility, Benefits and Claim Status will be available exclusively at availity.com. Please register and begin to access this information using Availity.

Other valuable resources

Provider Access offers an Overview page that includes quick access to online provider manuals, Claims processing edit information and medical policies. In addition, information regarding the following topics is also available on our web site:

• Pharmacy Management Procedures/Updates
• Health Improvement Programs
• Clinical Practice Guidelines
• Quality Improvement Activities
• Obtaining Utilization Management Criteria

If you would like to request a hard copy of any of the information listed above, please contact Provider Services at 800-241-7475 Monday through Friday from 8:00 am – 7:00 pm EST.

Provider Access complements Network Update, our newsletter that contains updates about policy and procedure changes, best practices, legislative and regulatory initiatives and new therapy advisories. Through Provider Access, Providers also have the ability to offer feedback to BCBSGa and make suggestions about topics they would like to see included.

Availity

A free, secure multi-health plan portal

Availity’s secure multi-health plan web portal – available at no charge to physicians and other providers – improves efficiencies through simplified and streamlined health plan administration.

Get the information you need instantly

Providers in Georgia can access real-time eligibility, benefits, and claims status information and much more through one secure web portal at www.availity.com. Submit simple batch eligibility and benefit inquiries for multiple patients with multiple plans and receive a consolidated response in a consistent format.

• Member eligibility and benefits inquiry – includes out-of-state BlueCard® members
• Claim status inquiry – includes out-of-state BlueCard members
• Claim submission – submit a single claim
• Secure messaging – submit a question on a claim via a secured email to the appropriate provider inquiry area.
• Patient360 (formerly known as Patient care summary) – real-time, consolidated view of a member’s medical history across multiple providers.
• Care reminders (formerly clinical messaging) – clinical alerts on patients’ care gaps and medication compliance indicators.
• AIM Specialty HealthSM (AIM) – link to precertification requests and inquiries through AIM.
- Member Certificate Booklet – view a local plan member’s certificate of coverage, when available.
- Online Remits* – link to online remits under Payer Spaces-Remittance Inquiry.
- Interactive Care Reviewer - secure, online provider precertification, referral and inquiry too.
- Payer Spaces – Payer Spaces on the Availity Web portal is designed to make it easy for you to navigate to proprietary payer applications, resources and information.

*The user must be registered with ProviderAccess for these roles.

Take advantage of the many benefits of using Availity

Benefits include:
- No charge – Health plan transactions are available at no charge to providers.
- Accessibility – Availity functions are available 24 hours a day from any computer with Internet access.
- Standard responses – Responses from multiple payers returned in the same format and screen layout, providing users with a consistent look and feel.
- Commercial and Government Payers – Access to data from BCBSGa, Medicare, Medicaid and other commercial carriers. (See www.availity.com for a full list of payers)
- Compliance –Compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

Payer Spaces

Payer Spaces on the Availity Web portal is designed to make it easy for you to navigate to proprietary payer applications, resources and information. The link is located on the right hand side of the Availity Web Portal’s top menu bar. The Payer Spaces drop down menu gives you the option to select Blue Cross Blue Shield of Georgia, (as shown in the illustration below) in addition to other payers with whom your organization is registered on the Availity Web Portal.

On the Payer Spaces landing page you will see three links: Applications, Resources, News and Announcements.

- Applications is where you access Remittance Inquiry and Professional Fee Schedule. Note: The applications that you see are dependent on what is available to you in your state or region and your assigned role on the Availity Web Portal.
- Resources houses online forms and information, including the online Provider Maintenance Form and Research Procedure Code Edits.
- News and Announcements is not yet an active link but will eventually contain news and updates proprietary to Blue Cross Blue Shield of Georgia providers.

If a new application or resource is added, you will see a number next to the links indicating how many new items have been added in the last 30 days. The recently added applications and forms are called out with the word NEW. In order to see the applications or certain resources, you will need to have the appropriate roles assigned to you by your Availity Administrator or Administrator Assistant.

Interactive Care Reviewer (ICR)

BCBSGa’s Interactive Care Reviewer (ICR) is the preferred method for the submission of pre-authorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for members covered by BCBSGa plans. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR or other online tool).

- Initiate pre-authorization requests online, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- Make inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Instant accessibility from almost anywhere including after business hours.
• **Utilize the dashboard** to provide a complete view of all UM Requests with real time status updates including email notifications if requested using a valid email address.

• **Real time results** for some common procedures with immediate decisions.

• **Access ICR** under Authorizations and Referrals via the Availity Web Portal.

To register for an ICR webinar use the attached link: [ICR Webinar](#)

For an optimal experience with **BCBSGa’s Interactive Care Reviewer (ICR)** use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox or Safari.

**BCBSGa’s Interactive Care Reviewer (ICR)** is not currently available for the following:

- FEP Members
- BlueCard®
- Some National Account Members
- Transplant services
- Services administered by vendors such as AIM Specialty Health® and OrthoNet LLC. *(For these requests, follow the same pre-authorization process that you use today.)*

Our website will be updated as additional functionality and lines of business are added throughout the year.

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**Eligibility**

**Covered Individual Identification and Verification**

Providers may identify and verify benefits for BCBSGa Covered Individuals by:

**On-line Access**

For all BCBSGa Health Benefit Plans, Providers can obtain eligibility verification online at [www.availity.com](http://www.availity.com). Providers can access information once a logon ID and password have been entered. For more information, please visit our web site.

**Covered Individual ID card**

All Covered Individuals are issued a Covered Individual ID card. Covered Individuals are responsible for presenting their current Covered Individual ID card when receiving Health Services. The Covered Individual card is for identification purposes only and may not be used to verify eligibility. HMO/POS Covered Individuals’ ID cards will include his/her PCP’s name and telephone number (when required). Samples of Covered Individual ID cards are on the following pages. These cards contain:

- Covered Individual name – identifies the Covered Individual
- Covered Individual ID number – the number used to identify each covered family member. The ID number has two parts: the Covered Individual’s unique personal number and a two-digit suffix. The suffix indicates the Covered Individual’s family member status under the contract. Each Covered Individual has his or her own ID card.
- Group number – the number assigned to identify the employer group to which the Covered Individual belongs.
- Group name – identifies the name of the employer group.
- PCP name and phone number – Federal Employee Health Benefit Program (FEHB), Blue Open Access and POS ID cards do not list the PCP.
- Effective date – the latest date of benefits or the most recent update.
• Additional information – including Claims filing address and referral authorization and pre-authorization phone numbers are shown on the back of the Covered Individual ID card.
• Co-payment – dollar amount the Covered Individual is responsible for paying the Provider at the time of service.

Network - Knowing the member’s network will assist you in identifying the applicable reimbursement schedule. You need to have this information when registering members in your office. The network (BlueChoice, Blue Open Access) will be in the upper, right-hand corner of the identification card and/or at the bottom of the card. Be sure this is the network in which you participate and that you refer the member to other service providers within their network if needed. Members who receive services outside of their network may have no benefits or reduced benefits which could impact the member's financial responsibilities as well as the potential payment for healthcare providers. Be sure to look first for the local network name on the card (BlueChoice or Blue Open Access). If you do not see a local network name on the card, then refer to the suitcase logo on the card to identify the network. A blank suitcase logo on a member’s ID card means that the member may access our Traditional network subject to their group’s benefits. If there is no local network name on the card, and there is a “PPO in a suitcase” logo, the Blue Choice PPO network applies.

Reminder:
• First look for Blue Choice, Blue or Open Access on the card.
• If Blue Choice or Blue Open Access is not on the card, check the suitcase.

Please note – The layout of the member ID cards can vary by product.
The logo will be displayed in the upper left hand corner.

- Member Name (First Middle Last)
- ID Number
- Prefix

Product Name / Prescription Drug information, if applicable / Medical copay information

The PPO/empty suitcase and prescription drug logo will be displayed at the bottom right, if applicable.
Front of the card
Blue Open Access w/Rx benefits

The logo will be displayed in the upper left hand corner.

- Member Name (First Middle Last)
- ID Number
- Prefix

Group / Product Information

Network Name

Product Name / Prescription Drug information, if applicable / Medical copay information

The PPO/empty suitcase and prescription drug logo will be displayed at the bottom right, if applicable.

Back of the card

bcbsga.com

Member Services 1-800-441-2273

24/7 Nurse Line 1-888-734-2583

Behavioral Health 1-800-392-2979

Coverage While Traveling 1-800-816-2983

Pharmacy Services 1-800-882-7378

Pre Certification 1-800-562-9023

Dental Services 1-800-827-9004

Dental TDD 1-800-788-9084

Blue Cross Blue Shield is a registered mark of an independent third party licensed to Georgia Blue Cross Blue Shield Association.
The logo will be displayed in the upper left hand corner.

- Member Name (First Middle Last)
- ID Number
- Prefix

Group / Product Information

Network Name

Product Name / Prescription Drug information, if applicable / Medical copay information

The PPO/empty suitcase and prescription drug logo will be displayed at the bottom right, if applicable.
The logo will be displayed in the upper left hand corner.

- Member Name (First Middle Last)
- ID Number
- Prefix

Group / Product Information

Network Name

Product Name / Prescription Drug information, if applicable / Medical copay information

The PPO/empty suitcase and prescription drug logo will be displayed at the bottom right, if applicable.
Front of the card

BlueChoice HMO

- Member Name (First Middle Last)
- ID Number
- Prefix

Group / Product Information

Network Name

The logo will be displayed in the upper left hand corner.

Product Name / PCP / Prescription Drug information, if applicable / Medical copay information

The PPO/empty suitcase and prescription drug logo will be displayed at the bottom right, if applicable.

Back of the card

- Member Services: 1-855-361-8027
- Pharmacy: Please submit pharmacy claims using the NABIN and Plan Code displayed on the front of the card
- All hospital admissions require preauthorization

Issue Date: [PROCESSED_DATE]
The logo will be displayed in the upper left hand corner.

- Member Name (First Middle Last)
- ID Number
- Prefix

Group / Product Information

Network Name

Product Name / Prescription Drug information, if applicable / Medical copay information

The PPO/empty suitcase and prescription drug logo will be displayed at the bottom right, if applicable.
Front of the card
State Health Benefit Plan Member ID card

The logo will be displayed in the upper left hand corner.

- Member Name (First Middle Last)
- ID Number
- Prefix

Group / Product Information

Network Name

Back of the card

Product Name / Prescription Drug information, if applicable / Medical copay information

The PPO/empty suitcase and prescription drug logo will be displayed at the bottom right, if applicable.
Front of the card

State Health Benefit Plan Member ID card Medicare Preferred (PPO)

The logo will be displayed in the upper left hand corner.

- Member Name (First Middle Last)
- ID Number
- Prefix

Group / Product Information

Network Name

Product Name / Prescription Drug information, if applicable / Medical copay information

The PPO/empty suitcase and prescription drug logo will be displayed at the bottom right, if applicable.

Back of the card

The logo will be displayed in the upper left hand corner.

- Member Name (First Middle Last)
- ID Number
- Prefix

Group / Product Information

Network Name

Product Name / Prescription Drug information, if applicable / Medical copay information

The PPO/empty suitcase and prescription drug logo will be displayed at the bottom right, if applicable.
Provider Service Line

We provide Covered Individual eligibility and benefits verification via telephone to Providers. Providers may call the Provider Service line toll free at 800-241-7475 from 8 a.m. to 7 p.m. Simply follow the prompts to obtain eligibility information.

The following information is required to verify a Covered Individual’s eligibility and benefits and/or to inquire on the status of a submitted Claim:

- Type of Health Benefit Plan (i.e.: BlueChoice HMO, FEHBP, etc.),
- Covered Individual’s name,
Electronic Inquiry

Basic Covered Individual and benefits eligibility information is available electronically.

Please refer to the Covered Individuals section of this manual for details about Covered Individuals issues and processes.

Checking status on Claims submitted to BCBSGa:

- A Claim’s status may be verified via the Internet at www.availity.com.
- Please wait at least thirty (30) calendar days after submitting a Claim before checking the Claim status via our web site or calling BCBSGa to verify the status of the Claim. This will allow sufficient time for complete processing of the Claim.
- If the Claim is submitted electronically, verify that the Claim was not rejected electronically and if rejected, and the Claim status is not available through our web site, that it was corrected and resubmitted.
- The status of the Claim may also be obtained by calling the appropriate BCBSGa telephone number based on the Covered Individual’s Health Benefit Plan.

Claims Submission

HMO/POS and Blue Open Access

All services provided must be reported in the standard HIPAA compliant Claim format using HIPAA-compliant code sets on the appropriate Claim form or the equivalent, within the filing standards timeframe, and with applicable charges noted. This is necessary for reporting of utilization data and HEDIS purposes. The Claim system will identify codes eligible for fee-for-service payment and will approve those services when appropriate.

Claims for Covered Individuals of all products may be mailed to:
Mail Claims to address on back of Covered Individual ID Card

Claims and encounters can also be filed electronically. For further information about electronic filing, please contact EDI Services at 1-888-883-2720. Procedures for electronic Claims filing are also available on our web site, www.bcbsga.com, and the Electronic Transaction Manual is available under EDI Services.

Filing Claims – All Products

Providers are required to accept the Covered Individual’s ID card in lieu of payment up-front and to file Claims for Covered Individuals.

All services provided to Covered Individuals must be filed using the standard HIPAA compliant Claim format and HIPAA compliant code sets on the appropriate Claim form or the equivalent, within the filing standards timeframe, and with applicable charges noted.

The charges for services rendered to Covered Individuals and Guest Covered Individuals should be at the same rate as for all other patients and Claims should be submitted to BCBSGa within the filing standards timeframe.
Mail hardcopy Claim forms to the address indicated on the ID card.

We encourage all providers to file Claims electronically. For further information about electronic filing, please contact EDI Services at 888-883-2720. Procedures for electronic Claims filing are also available on our web site, www.bcbsga.com, and the Electronic Transaction Manual is available under EDI Services.

The following information is required for submitting electronic and/or hard copy Claims to BCBSGa:

- Current ICD-10 or successor diagnosis codes, HCPCS and CPT-4 procedure codes. (There should be only one procedure code per line and codes should be listed to the fifth digit. HCPCS and CPT-4 procedure codes should include modifiers where applicable.)
- Complete all fields and submit on standard pre-printed UB04, CMS 1500 or successor forms. The following are examples of significant data elements:
  - Valid bill types and revenue codes
  - Diagnosis code(s)
  - Provider name and tax ID
  - Dates of service (admit and discharge dates)
  - Complete and accurate Covered Individual and insurance information including:
    - Alpha prefix and numeric suffix with Covered Individual’s ID number
    - Correct spelling of the Covered Individual’s name
    - Date of birth and sex of Covered Individual

Additional information for submitting Claims:

- Include CPT codes for revenue codes such as radiology, pathology and surgery.
- Include the actual CPT code only once for each revenue line.
- Submit all revenue codes with a dollar value.
- Submit therapy charges with the number of units equal to the number of days these services were rendered and not the number of modalities per service.
- Check formatting and print quality of hard-copy Claims before submission. Unaligned data elements and light print may prevent your Claims from being processed.
- Include primary payment information with coordination of benefits (“COB”) Claims submitted for secondary payment.
- Obtain required pre-authorizations and include the pre-authorization number on the Claim.
- Use the prefix given on the Covered Individual ID card that precedes the Covered Individual ID number.
- Verify eligibility and benefit limits before rendering services.
- Rubber-stamp the type of Claim (e.g. adjustment, corrected bill, tracer, etc.) on the face of hard-copy bills to ensure correct identification. Do not use red ink when stamping, because the scanning equipment may not be able to read this information.
- Check the back of the Covered Individual’s insurance card for the correct mailing address for hard copy Claim submissions.

Common reasons for rejected Claims (i.e., Claims that cannot be processed):

- Outdated, incomplete or non-specific ICD-10 or successor, HCPCS and/or CPT codes on the Claim.
- Incomplete data elements.
- Invalid or incorrect contract information (i.e. Covered Individual number).
- Ineligible Covered Individual for BCBSGa coverage.
- Illegible hard-copy Claims. (Note: Rejected hardcopy Claims will be mailed back to the sender along with a request for additional information that is necessary to process the Claim.)

Claims for Agreements that require itemized bills or invoices to be submitted with Claims should not be submitted electronically:

The following are tips for resubmitting Claims:

- Please verify that the Claim has not been received by BCBSGa and do not resubmit Claims until at least thirty (30) calendar days have passed from the original date of submission.
• Resubmitted Claims will be denied as duplicates when the original Claim has already been received by BCBSGa unless changes have been made and the new Claim is identified as an adjusted/corrected Claim. Corrected bills are those Claims for which a remittance advice has already been received by the Provider.

Ancillary Claims Filing

Ancillary claims for Independent Clinical laboratory, Durable/Home Medical Equipment and Supply, and Specialty Pharmacy are filed to the local plan. The local Plan, as defined for ancillary services, is the Plan in whose area the ancillary services were rendered.

Independent Lab- Local Plan= The Plan in whose service area the specimen was drawn.

Durable/Home Medical Equipment – The Plan in whose service the equipment was shipped to or purchased at a retail store.

Specialty Pharmacy – The Plan in whose service area the order physician is located.

Electronic Claim Acceptance/Rejection Validation

Important information to validate acceptance/rejection status for submitted electronic Claims:

• For each electronically submitted batch of Claims, Medical Data Delivery (“MDD”) reports are provided by BCBSGa. The MDD reports should be available in the provider/vendor electronic mailbox approximately four hours after transmission.
• Providers should note the date of transmission and access these reports after each transmission to:
  • Ensure that BCBSGa has received the transmitted batch.
  • Reconcile the submitted batch’s total number of Claims and total dollars to the MDD reports for completeness and accuracy.
  • Identify errors and/or rejected Claims for timely correction and resubmission.

Types of MDD Reports and their use:

• Accepted Batch Summary: This report lists summary totals that should be reconciled to the submitted batch’s total number of Claims and total dollars to ensure completeness and accuracy.
• Accepted Batch Report: This report provides a detailed listing of all Claims received within an accepted batch.
• Rejected Batch Report: This report is produced when an entire batch is rejected. The reason for the rejection of the batch and individual Claims are indicated on this report. The batch and the individual Claims should be corrected for timely resubmission.
• Claims Error Report: This report individually lists Claims that were rejected within an accepted batch. The reasons for the rejection of these Claims should be corrected for timely resubmission.
• It should be noted that vendor supported sites should first contact their appropriate vendor when encountering transmission problems with EDI Claims.
• Providers may also contact the following phones numbers for questions pertaining to electronic submissions:
  • (888) 883-2720 for vendor supported sites.
  • (800) 638-9677 for Network Plus customers.

Requests for Clinical Information

There is a standard cover sheet, found in the exhibits section, for submitting clinical information when filing an initial paper Claim. Using this cover sheet will help ensure that documentation is “attached” to the right Claim(s) and will expedite processing.

You may also use this form when you know in advance that BCBSGa requires clinical information (such as an unlisted procedure code).

If you have received a request for clinical information and if you have the Claim number, you may also use this form to submit supporting documentation. VERY IMPORTANT NOTE: If BCBSGa has requested clinical
information, please follow the instructions in the request/letter and attach a copy of the request/letter as the cover sheet. The bar coding helps to expedite processing!

YOU CAN FAX (IF LESS THAN 25 PAGES) OR MAIL YOUR COVER SHEET AND INFORMATION TO:
Blue Cross Blue Shield of Georgia
2357 Warm Springs Road
Columbus, GA 31904
Fax: 1-877-868-7950

Clinical Submission Categories

The following is a list of Claims categories where we may routinely require submission of Clinical Information before or after payment of a Claim:

- Claims involving pre-certification/prior authorization/pre-determination (or some other form of utilization review including but not limited to:
  - Claims pending for lack of precertification or prior authorization.
  - Claims involving Medical Necessity or Experimental/Investigative determinations.
  - Claims for pharmaceuticals requiring prior authorization.
- Claims involving certain modifiers, including but not limited to Modifier 22.
- Claims involving unlisted codes.
- Claims for which we cannot determine from the face of the Claim whether it involves a Covered Service thus the benefit determination can’t be made without reviewing medical records (including but not limited to pre-existing condition issues, emergency service-prudent layperson reviews, and specific benefit exclusions).
- Claims that we have reason to believe involve inappropriate (including fraudulent) billing.
- Claims that are the subject of an audit (internal or external) including high dollar Claims.
- Claims for individuals involved in case management or disease management.
- Claims that have been appealed (or that are otherwise the subject of a dispute, including Claims being mediated, arbitrated, or litigated).
- Other situations in which clinical information might routinely be requested:
  - Requests relating to underwriting (including but not limited to Covered Individual or physician misrepresentation/fraud reviews and stop loss coverage issues);
  - Accreditation activities;
  - Quality improvement/assurance activities;
  - Credentialing;
  - Coordination of benefits; and
  - Recovery/subrogation.

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

Claims Processing

Payor System Edits:

- In addition to EDI edits, certain operating system edits may prevent the Claim from automatically adjudicating. These suspended Claims may require additional information to complete processing. It is important that the information requested be provided in a timely manner.

Medical Review Process:

- For Claims requiring medical review, providers will be notified of the required information to be submitted and where to mail or fax the information.
- To avoid denials, it is important that the requested information be submitted within the time period indicated on the letter of request.
Medical Management/Appeals Process:

- Appeals are formal requests, either oral or written, expressing dissatisfaction with a decision not to certify an admission, requesting an extension of a Covered Individual’s stay, or other Health Services or procedures.
- If the provider remains dissatisfied after receiving the initial decision, he or she may initiate a complaint by sending documentation, including a cover letter outlining the issue. If the complaint is ten (10) pages or fewer, the complaint can be faxed to 1-888-859-3046. For longer documents, the provider can mail to:

  BCBSGa
  Attn: Provider Appeals
  P.O. Box 105449
  Atlanta, GA 30348-5449

- Appeal of initial determination:
  - Appeals can be initiated by the Covered Individual or the provider.
  - Decisions are generally made within sixty (60) business days after receipt of necessary documentation.

Ambulatory Surgery Centers billing requirement

BCBSGa requires Ambulatory Surgery Centers (ASC) to submit their claims on a UB04. Claims submitted by an ASC on any form other than a UB04 may be subject to rejection. Medicare Crossover claims are the only exception to this requirement.

Electronic Data Interchange (“EDI”) Overview

BCBSGa recommends using the EDI system for Claims submission. Electronic Claims submissions can help reduce administrative and operating costs, expedite the Claim process, and reduce errors. Providers and Facilities who use EDI can electronically submit Claims and receive acknowledgements 24 hours a day, 7 days a week.

Electronic Funds Transfer Election - Should Provider or Facility elect to receive payments via Electronic Fund Transfer, such election may be deemed effective by BCBSGa for any Claim your Agreement with BCBSGa pertains to. BCBSGa may share information about Providers or Facilities, including banking information, with third parties to facilitate the transfer of funds to Provider or Facility accounts.

There are several methods of transacting BCBSGa Claims through the Electronic Data Interchange process. You can use electronic Claims processing software to submit Claims directly, or you can use an EDI vendor that may also offer additional services, including the hardware and software needed to automate other tasks in your office. No matter what method you choose, BCBSGa does not charge a fee to submit electronically. Providers and Facilities engaging in electronic transactions should familiarize themselves with the HIPAA transaction requirements.

Additional Information

For additional information concerning electronic Claims submission and other electronic transactions, you can click the Electronic Data Interchange (EDI) link below or go to bcbsga.com/edi.


Provider and Facility Identified Overpayments (aka “voluntary” or “unsolicited”)

If BCBSGa is due a refund as a result of an overpayment discovered by a Provider or Facility, refunds can be made in one of the following ways:

- Submit a refund check with supporting documentation outlined below, or
• Submit the Provider General Correspondence Form with supporting documentation to have claim adjustment/recoupment done off a future remittance advice

When voluntarily refunding BCBSGa on a Claim overpayment, please include the following information:

• Provider General Correspondence Form (see directions below for how to access online))
• All documents supporting the overpayment including EOBs from BCBSGa and other carriers as appropriate
• Covered Individual ID number
• Covered Individual's name
• Claim number
• Date of service
• Reason for the refund as indicated in the list above of common overpayment reasons

Please be sure the copy of the provider remittance advice is legible and the Covered Individual information that relates to the refund is circled. By providing this critical information, BCBSGa will be able to expedite the process, resulting in improved service and timeliness to Providers and Facilities.

**Important Note:** If a Provider or Facility is refunding BCBSGa due to coordination of benefits and the Provider or Facility believes BCBSGa is the secondary payer, please refund the full amount paid. Upon receipt and insurance primacy verification, the Claim will be reprocessed and paid appropriately.

**How to access the Provider General Correspondence Form online:**

To download the “Provider General Correspondence Form” directly from BCBSGa.com, Select **Menu**, and then under the **Support** heading select the **Providers** link. Choose Georgia from the drop down box and press enter. On the provider home page, select Answers@BCBSGA on the menu bar. On the Answers@BCBSGA page, select “Provider General Correspondence Form”.

**Please utilize the proper address noted in the grid below to return payment:**

<table>
<thead>
<tr>
<th>State</th>
<th>Line of Business (Blue Branded)</th>
<th>Type of Refund</th>
<th>Make Check Payable To:</th>
<th>Regular Mailing Address:</th>
<th>Overnight Delivery Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>All Voluntary</td>
<td>Blue Cross Blue Shield of Georgia</td>
<td>Central Region- CCOA Lockbox PO Box 73651 Cleveland, OH 44193-1177</td>
<td>BCBSGa Central Lockbox 73651 4100 West 150th Street Cleveland, Ohio 44135</td>
<td></td>
</tr>
<tr>
<td>GA</td>
<td>All Solicited Refund with Coupon Letter</td>
<td>Blue Cross Blue Shield of Georgia</td>
<td>BCBSGa PO Box 5281 Carol Stream, IL 60197</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Reimbursement and Billing Policies**

**Medical Care Provided to or by Family Members**

Services for any type of medical care rendered by a Provider to him/herself or to an immediate family member (as defined below), who is a Covered Individual, are not eligible for coverage and should not be billed to BCBSGa. In addition, a Provider may not be selected as a Primary Care Physician (PCP) by his/her immediate family member.

Changes During Admission

There are 5 (five) elements that could change during an admission. The following table shows the scenarios and the date to be used:

<table>
<thead>
<tr>
<th>CHANGE</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Individual’s Insurance Coverage</td>
<td>Discharge</td>
</tr>
<tr>
<td>Facility’s Payment Methodology</td>
<td>Discharge</td>
</tr>
<tr>
<td>Facility’s Payment Rate</td>
<td>Discharge</td>
</tr>
<tr>
<td>DRG Grouper Version</td>
<td>Discharge</td>
</tr>
<tr>
<td>DRG Relative Weight</td>
<td>Discharge</td>
</tr>
</tbody>
</table>

Claim Payment

- Separate checks are issued for FEHBP, University System of Georgia and BCBSGa Plans.
- Adjusted/corrected Claim payments are issued daily or are included with the regular check if the payment date falls on the provider’s issuance date.
- BCBSGa will reimburse Provider s to the extent applicable to particular Claims payment and reimbursement consistent with O.C.G.A 33-24-59.5.

Coordination of Benefits/Subrogation

If a Plan is other than the primary payor, any further compensation to Provider from Plan or the Covered Individual will be determined in accordance with the Agreement, the applicable Health Benefit Plan and any applicable Plan written policies and procedures for coordinating benefits. Such compensation from Plan as a secondary payer plus the amounts owed by all other sources, including the Covered Individual, shall add up to one hundred percent (100%) of the Plan rate.

Notwithstanding the foregoing, in no event shall Plan or the Covered Individual be required to pay more than they would have paid had the Plan been the primary payor. Provider will not collect any amount from the Covered Individual if such amount, when added to the amounts collected from the primary and secondary payors, would cause total reimbursement to Provider for the Covered Service to exceed the amount allowed for the Covered Service under the Agreement. Further, this provision shall not be construed to require Provider to waive Cost Share in contravention of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation. If, under this Section, Provider is permitted to seek payment from other sources by reason of the existence of other group coverage in addition to Plan’s Health Benefit Plan. Provider may seek payment from the other sources on a basis other than the Plan Rate.

Co-Payments, Co-insurance and Deductibles

Covered Individuals are only responsible for co-payments, co-insurance or deductibles. These are printed on the Covered Individual’s ID card.

A physician co-payment may be collected for any visit at which a physician or healthcare professional sees a Covered Individual and an office visit CPT procedure code is filed on the Claim. The co-payment should not be collected if the Covered Individual is only assisted by the administrative staff (examples: picking up a prescription or requisition or drawing for laboratory tests).

Group benefits may supersede the co-payment allocation. Please verify the Covered Individual’s eligibility and benefits to determine the appropriate collection of the Covered Individual’s co-payment.

Co-insurance and deductibles should be collected from the Covered Individual only after you have received the remittance which will indicate the correct amount of Covered Individual liability.
Under the Covered Individual agreements, BCBSGa Covered Individuals and Guest Covered Individuals may also be responsible for paying some portion of the bill for Health Services rendered by Network Facilities. Covered Individuals may be responsible for any of the following: emergency room co-payments, deductibles, coinsurance, and non-Covered Services.

- **Co-payment** – a fixed payment made by Covered Individual at the time a service is rendered.
- **Deductibles** – a fixed dollar amount that Covered Individuals must pay out-of-pocket for Covered Services before BCBSGa will pay benefits.
- **Coinsurance** – Coinsurance is usually a fixed percentage of the allowed charges for Covered Services.
- **Non-Covered Services** – a service not covered under the terms of the Covered Individual Health Benefit Plan. BCBSGa Covered Individuals are responsible for payment for services that are not covered under their Covered Individual Health Benefit Plan. Refer to Notice of Potential Liability for in the exhibits section.

If possible, BCBSGa Covered Individuals should pay their co-payments at the time services are rendered. The Covered Individual ID card will indicate if the Covered Individual’s coverage includes a co-payment. Providers will receive a remittance advice reporting Plan payment for services and amounts billable to the Covered Individual. Covered Individuals should not be billed for charges associated with those services which do not appear as Covered Individual liability on the remittance advice. Providers should call the customer care department with any questions regarding Plan payment or Covered Individual liabilities.

**Eligibility and Payment**

A guarantee of eligibility is not a guarantee of payment.

**Facility Personnel Charges**

Charges for Inpatient Services for Facility personnel, excluding physicians and mid-level providers, are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions, call back charges, nursing increments and respiratory services. Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

**General Industry Standard Language**

Per our policy and the Agreement, providers will follow industry standards related to billing. Examples of general industry standards include but are not limited to HCPCS, ICD10/CM or successor codes, health service codes (also known as Revenue Codes) per the UB-04 definition manual, or subsequent forms and CPT methodology.

**Implants**

Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert, placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Covered Individual's body upon discharge from the inpatient stay or outpatient procedure. Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants.

Facility shall not bill BCBSGa for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Covered Individual. Additionally, BCBSGa will not reimburse Facility for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Covered Individual.

**Labor Care Charges**
Plan will reimburse appropriately billed room and board or labor charges. Payment will not be made on both charges billed concurrently. Facilities reimbursed under DRG may not bill for Outpatient Services rendered immediately prior to the admission.

**Observation Services Policy**

**Description**

BCBSGa considers outpatient observation services to mean active, short-term medical and/or nursing services performed by an acute facility on that facility’s premises that includes the use of a bed and monitoring by that acute facility’s nursing or other staff and are required to observe a patient’s condition to determine if the patient requires an inpatient admission to the facility. Observation services include services provided to a patient designated as “observation status”, and in general, shall not exceed 24 hours. Observation services may be considered eligible for reimbursement when rendered to patients who meet one or more of the following criteria:

- Active care or further observation is needed following emergency room care to determine if the patient is stabilized.
- The patient has a complication from an outpatient surgical procedure that requires additional recovery time that exceeds the normal recovery time.
- The patient care required is initially at or near the inpatient level; however, such care is expected to last less than a 24 hour time frame.
- The patient requires further diagnostic testing and/or observation to make a diagnosis and establish appropriate treatment protocol.
- The patient requires short term medical intervention of facility staff which requires the direction of a physician.
- The patient requires observation in order to determine if the patient requires admission into the facility.

**Policy**

The payment, if any, for observation services is specified in the Plan Compensation Schedule or Contract with the applicable Facility. Nothing in this Policy is intended to modify the terms and conditions of the Facility’s agreement with BCBSGa. If the Facility’s agreement with BCBSGa does not provide for separate reimbursement for observation services, then this Policy is not intended to and shall not be construed to allow the Facility to separately bill for and seek reimbursement for observation services.

The patient’s medical record documentation for observation status must include a written order by the physician or other individual authorized by state licensure law and facility staff bylaws to admit patients to the facility that clearly states “admit to observation”. Additionally, such documentation shall demonstrate that observation services are required by stating the specific problem, the treatment and/or frequency of the skilled service expected to be provided."

The following situations are examples of services that are considered by BCBSGa to be inappropriate use of observation services:

- Physician, patient, and/or family convenience
- Routine preparation and recovery for diagnostic or surgical procedures
- Social issues
- Blood administration
- Cases routinely cared for in the Emergency Room or Outpatient Department
- Routine recovery and post-operative care after outpatient surgery
- Standing orders following outpatient surgery
- Observation following an uncomplicated treatment or procedure
Non-Covered Use of Observation Beds

Services related to observation beds that are not reimbursable, include but are not limited to the following instances:

1. Services provided for the convenience of the physician, patient and/or family;
2. Services that are benefit exclusions;
3. Services rendered from the start of outpatient surgery until discharge from recovery room;
4. Services following routine diagnostic procedures such as endoscopies; and
5. Services not adequately supported by clinical documentation.

Observation Services, Proper Billing of

Facility shall report observation charges under Revenue Code 762. CPT Codes are not required to be reported under Revenue Code 762. The only appropriate CPT Codes, if reported, are 99217 through 99220 and 99234 through 99236. Facility shall report the number of hours the Covered Individual is in observation status in the units field. Facility shall report any additional services performed while the Covered Individual is in observation status under the appropriate Revenue Code for those services.

Personal Care Items

Personal care items used for Covered Individual convenience are not reimbursable. Examples include but are not limited to: deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, slippers, toothbrush and toothpaste. Items used for the Covered Individual which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable or billable to the Covered Individual. Examples include but are not limited to: bedpans, chux, hot water bottles, icepacks, sitz baths, and urinals.

Preventable Adverse Events (“PAE”) Policy

Acute Care General Hospitals Inpatient

Three (3) Major Surgical Never Events

When any of the Preventable Adverse Events (“PAEs”) set forth in the grid below occur with respect to a Covered Individual, the acute care general hospital shall neither bill, nor seek to collect from, nor accept any payment from the Plan or the Covered Individual for such events. If acute care general hospital receives any payment from the Plan or the Covered Individual for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, acute care general hospital shall cooperate with BCBSGa, in any BCBSGa initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid, below, occur with respect to a Covered Individual, acute care general hospital is encouraged to report the PAE to the appropriate state agency, The Joint Commission (“TJC”), or a patient safety organization (“PSO”) certified and listed by the Agency for Healthcare Research and Quality.

<table>
<thead>
<tr>
<th>Preventable Adverse Event</th>
<th>Definition / Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Surgery Performed on the Wrong Body Part</td>
<td>Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>2. Surgery Performed on the Wrong Patient</td>
<td>Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
</tbody>
</table>
3. **Wrong surgical procedure performed on a patient**
   Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.

**CMS Hospital Acquired Conditions ("HAC")**

BCBSGa follows CMS’ current and future recognition of HACs. Current and valid Present on Admission ("POA") indicators (as defined by CMS) must be populated on all inpatient acute care Facility Claims.

When a HAC does occur, all inpatient acute care Facilities shall identify the charges and/or days which are the direct result of the HAC. Such charges and/or days shall be removed from the Claim prior to submitting to the Plan for payment. In no event shall the charges or days associated with the HAC be billed to either the Plan or the Covered Individual.

**Providers and Facilities (excluding Inpatient Acute Care General Hospitals)**

**Four (4) Major Surgical Never Events**

When any of the Preventable Adverse Events ("PAEs") set forth in the grid below occur with respect to a Covered Individual, the Provider or Facility shall neither bill, nor seek to collect from, nor accept any payment from the Health Plan or the Covered Individual for such events. If Provider or Facility receives any payment from the Plan or the Covered Individual for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Providers and Facilities shall cooperate with BCBSGa, in any BCBSGa initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid, below, occur with respect to a Covered Individual, Provider is encouraged to report the PAE to the appropriate state agency, The Joint Commission ("TJC"), or a patient safety organization ("PSO") certified and listed by the Agency for Healthcare Research and Quality.

<table>
<thead>
<tr>
<th>Preventable Adverse Event</th>
<th>Definition / Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Surgery Performed on the Wrong Body Part</td>
<td>Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>2. Surgery Performed on the Wrong Patient</td>
<td>Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>3. Wrong surgical procedure performed on a patient</td>
<td>Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>4. Retention of a foreign object in a patient after surgery or other procedure</td>
<td>Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.</td>
</tr>
</tbody>
</table>
Reimbursement

In the event that a Provider who is not participating in the HMO/POS Network renders emergency services to an HMO/POS Covered Individual, the Provider will be reimbursed at their current Agreement (Prudent Buyer Program) rates. Providers not participating in the HMO/POS Network will be reimbursed at the Prudent Buyer Program rates for POS Covered Individuals when rendering non-emergency services. HMO Covered Individuals do not have out-of-Network benefits for non-emergency services.

Pricing methods include but are not limited to: Per Diem rates, Global Case rates, Per Visit rates, diagnosis related groupers (“DRGs”), surgical categories (“SCs”) and negotiated fee schedules.

Remittance Advice Reconciliation:

- Remittance advices are sent to Providers along with check payments. To ensure that remittance advice information is accurately and completely posted to Covered Individuals’ accounts, reconciliation should be performed for each payment.
- For questions concerning the remittance advice, please call the applicable customer service department based on the Covered Individual’s Health Benefit Plan coverage.
- Charges denied as provider liability should be written-off to prevent an overstatement of the accounts receivable balance.
- Covered Individuals may not be billed for the difference between the Provider’s charges and contracted amount.
- If you have questions concerning contractual issues, contact your local provider representative.

Test or Procedures Prior to Admission(s) or Outpatient Services

The following diagnostic services, defined by specific Coded Service Identifier(s), are considered part of pre-admission/pre-surgical/pre-operative testing:

- 254 – Drugs incident to other diagnostic services
- 255 – Drugs incident to radiology
- 30X – Laboratory
- 31X – Laboratory pathological
- 32X – Radiology diagnostic
- 341 – Nuclear medicine, diagnostic
- 35X – CT scan
- 40X – Other imaging services
- 46X – Pulmonary function
- 48X – Cardiology
- 53X – Osteopathic services
- 61X – MRI
- 62X – Medical/surgical supplies, incident to radiology or other services
- 73X – EKG/ECG
- 74X – EEG
- 92X – Other diagnostic services

Non-diagnostic services are also considered part of pre-admission/pre-surgical/pre-operative testing if they are furnished in connection with the principal diagnosis that necessitates the outpatient procedure or the Covered Individual’s admission as an inpatient.

Medical Policies

Medical Policy and Clinical Utilization Management (UM) Guidelines
The Office of Medical Policy & Technology Assessment (OMPTA) develops medical policy and clinical UM guidelines (collectively, “Medical Policy”) for BCBSGa. The principal component of the process is the review of development of medical necessity and/or investigational policy position statements, or clinical indications for certain new medical services and/or procedures, or for new uses of existing services and/or procedures.

The Medical Policy & Technology Assessment Committee (“MPTAC”), is the authorizing body for medical policy and clinical UM guidelines, which serve as a basis for coverage decisions. MPTAC is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting memberships includes external physicians in clinical practices and participating in networks; external physicians in academic practices and participating in networks; internal medical directors, and Chairs of MPTAC Subcommittees. Additional detail about the Medical Policy development process, including information about the MPTAC and its subcommittees is provided in ADMIN.00001 Medical Policy Formation.

For an explanation of our Medical Policy development process, please visit our website:
http://www.bcbsga.com/medicalpolicies/policies/mp_pw_a044135.htm

Medical Policy and Clinical Utilization Management (UM) Guidelines Distinction

Medical policy and clinical UM guidelines differ in the type of determination being made. In general, medical policy addresses the Medical Necessity of new services and/or procedures and new applications of existing services and/or procedures, while clinical UM guidelines focus on detailed selection criteria, goal length of stay (GLOS), or the place of service for generally accepted technologies or services. In addition, medical policies are implemented by all BCBSGa Plans while clinical UM guidelines are adopted and implemented at the local BCBSGa Plan discretion.

Medical Policies and Clinical UM Guidelines are posted online at bcbsga.com

All BCBSGa medical policies and clinical UM guidelines are publicly available on our website, which provides greater transparency for Providers and Facilities, Covered Individuals and the public in general. Some vendor guidelines used to make coverage determinations are proprietary and are not publicly available on the BCBSGa website but are available upon request from the vendor.

To locate medical policies or clinical UM guidelines online, go to bcbsga.com, select the Provider link in top center of the page. From the Provider Home tab, select the enter button from the blue box on the left side of page titled “Medical Policies, Clinical UM Guideline, and Pre-Cert Requirements”. (Please note medical policies and clinical UM guidelines are available for Local Plan members as well as BlueCard/Out-of-area members.)

Clinical UM Guidelines for Local Plan members

The clinical UM guidelines published on our website represent the clinical UM guidelines currently available to all Plans for adoption throughout our organization. Because local practice patterns, claims systems and benefit designs vary, a local Plan or lines of business may choose whether or not to implement a particular clinical UM guideline. The link below can be used to confirm whether or not the local Plan or line of business has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan or line of business.

To view the list of specific clinical UM guidelines adopted by BCBSGa, navigate to the Disclaimer page by following the instructions above; scroll to the bottom of the page. Above the “Continue” button, click on the link titled “Specific Clinical UM Guidelines adopted by BCBSGa

Utilization Management

Utilization Management Program

Providers and Facilities agree to abide by the following Utilization Management (“UM”) Program requirements in accordance with the terms of the Agreement and the Covered Individual’s Health Benefit Plan. Providers and Facilities agree to cooperate with BCBSGa in the development and implementation of action plans arising under these programs. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined below, including, but not limited to:

Pre-service Review & Continued Stay Review

A. Provider or Facility shall ensure that non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Plan are submitted for review as soon as possible before the service occurs. Information provided to the Plan shall include demographic and clinical information including, but not limited to, primary diagnosis.

B. Provider or Facility shall provide confirmation to BCBSGa UM with the demographic information and primary diagnosis within twenty-four (24) hours or next Business Day of a Covered Individual’s admission for scheduled procedures.

C. If an Emergency admission has occurred, Provider or Facility shall notify BCBSGa UM within twenty-four (24) hours or the first Business Day following admission. Information provided to the Plan shall include demographic and clinical information including, but not limited to, primary diagnosis.

D. Provider or Facility shall verify that the Covered Individual’s primary care physician has provided a referral as required by certain Health Benefit Plans.

E. Provider or Facility shall comply with all requests for medical information for Continued Stay Review required to complete Plan’s review and discharge planning coordination. To facilitate the review process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.

F. BCBSGa specific Pre-certification/Pre-authorization Requirements may be confirmed on the BCBSGa web site or by contacting customer service.

Medical Policies and Clinical UM Guidelines

Please refer to the Medical Policies and Clinical Utilization Management (UM) Guidelines section of this manual for additional information about Medical Policy and Clinical UM Guidelines.

On-Site Review

If Plan maintains an on-site Initial Request/Continued Stay Review program, the Facility’s UM program staff is responsible for following the Covered Individual’s stay and documenting the prescribed plan of treatment, promoting the efficient use of services and resources, and facilitating available alternative outpatient treatment options. Facility agrees to cooperate with BCBSGa and provide BCBSGa with access to Covered Individuals medical records, as well as, access to the Covered Individuals in performing on-site Initial Request/Continued Stay Review and discharge planning related to, but not limited to, the following:

- Emergency and/or maternity admissions
- Ambulatory surgery
- Case management
- Pre-admission testing (“PAT”)
- Inpatient Services, including Neo-natal Intensive Care Unit (“NICU”)
- Focused procedure review

Discharge Planning
Discharge planning includes the coordination of medical services and supplies, medical personnel and family to facilitate the Covered Individual’s timely discharge to a more appropriate level of care following an inpatient admission.

**Observation Bed Policy**

Please refer to the “Observation Services Policy” located in the Billing and Reimbursement Guidelines section of the Manual.

**Retrospective Utilization Management**

Retrospective UM is designed to review post service Claims for Health Services in accordance with the Covered Individual’s Health Benefit Plan and BCBSGa medical policy and clinical guidelines. Medical records and pertinent information regarding the Covered Individual’s care may be reviewed by health care professionals with review by peer clinical reviewers when necessary to determine the level of coverage for the Claim, if any. This review may consider such factors as the Medical Necessity of services provided, whether the Claim involves cosmetic or experimental/investigative procedures, or coverage for new technology treatment.

**Failure to Comply With Utilization Management Program**

Provider and Facility acknowledge that the Plan may apply monetary penalties such as a reduction in payment, as a result of Provider’s or Facility’s failure to provide notice of admission or obtain Pre-service Review on specified outpatient procedures, as required under this Agreement or for Provider’s or Facility’s failure to fully comply with and participate in any cost management programs and/or UM programs.

**Case Management**

Case Management is a voluntary Covered Individual Health Benefit Plan management program designed to support the use of cost effective alternatives to inpatient treatment, such as home health or skilled nursing facility care, while maintaining or improving the quality of care delivered. The nurse case manager in BCBSGa’s case management program works with the treating physician(s), the Covered Individual and/or the Covered Individual’s Authorized Representative, and appropriate Facility personnel to both identify candidates for case management, and to help coordinate benefits for appropriate alternative treatment settings. The program requires the consent and cooperation of the Covered Individual or Covered Individual’s Authorized Representative, as well as collaboration with the treating physicians.

A Covered Individual (or Covered Individual’s Authorized Representative) may self-refer or a Provider or Facility may refer a Covered Individual to BCBSGa’s Case Management program by calling the Customer Service number on the back of the member’s ID card.

**Utilization Statistics Information**

On occasion, BCBSGa may request utilization statistics for disease management purposes using Coded Services Identifiers. These may include, but are not limited to:
- Covered Individual name
- Covered Individual identification number
- Date of service or date specimen collected
- Physician name and/or identification number
- Value of test requested or any other pertinent information BCBSGa deems necessary

This information will be provided by Provider or Facility to BCBSGa at no charge to BCBSGa.

**Electronic Data Exchange**

Facility will support BCBSGa by providing electronic data exchange including, but not limited to, ADT (Admissions, Discharge and Transfer), daily census, confirmed discharge date and other relevant clinical data.

**Reversals**
Utilization Management determinations may be reversed if:

1. New information is received that is relevant to an adverse determination which was not available at the time of the determination, or;

2. The original information provided to support a favorable determination was incorrect, fraudulent, or misleading.

**Peer to Peer Review Process**

Upon the Providers request from an attending, treating or ordering physician, BCBSGa provides a clinical peer-to-peer review process where our internal peer clinical reviewers re-examine cases when an adverse medical necessity determination will be made or has been made regarding health care services for Covered Individuals. The attending, treating or ordering physician may offer additional information and/or further discuss his/her cases with our peer clinical reviewers who made the initial adverse determination.

**Initiating a Peer-to-Peer Request:** Providers can initiate a peer-to-peer request IF he/she is the attending, treating or ordering physician, Nurse Practitioner, or Physician Assistant who provides the care for which any adverse medical necessity determination is made. In compliance with nationally recognized guidelines from the National Committee for Quality Assurance (NCQA) and URAC, Provider or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

**Quality of Care Incident**

Providers and Facilities will notify BCBSGa in the event there is a quality of care incident that involves a Covered Individual.

**Audits/Records Requests**

At any time BCBSGa may request on-site, electronic or hard copy medical records, utilization review sheets and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

**UM Definitions**

1. **Pre-service Review.** Review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Covered Individual.

2. **Initial Request/Continued Stay Review** (continuation of services). Review for Medical Necessity during initial/ongoing inpatient stay in a facility or a course of treatment, including review for transitions of care and discharge planning.

3. **Pre-certification/Pre-authorization Request.** For BCBSGa UM team to perform Pre-service Review, the provider submits the pertinent information as soon as possible to BCBSGa UM prior to service delivery.

4. **Pre-certification/Pre-authorization Requirements.** List of procedures that require Pre-service Review by BCBSGa UM prior to service delivery.

5. **Business Day.** Monday through Friday, excluding designated company holidays.

**Notification.** The telephonic and/or written/electronic communication to the applicable health care Providers, Facility and the Covered Individual documenting the decision, and informing the health care Providers, Facility and Covered Individual of their rights if they disagree with the decision.
Credentialing

Credentialing Scope

A. Professional Practitioners:

1. Practitioner Types: BCBSGa credentials the following health care practitioners, when an independent relationship exists between BCBSGa and the Practitioner, or the individual Practitioner is listed individually in BCBSGa’s provider network directory; and exclusions in section 2 (see below) do not apply:

   - Medical Doctors (MD)
   - Doctors of Osteopathic Medicine (DO)
   - Doctors of Podiatry
   - Chiropractor
   - Optometrists providing Health Services covered under the Health Benefits Plan
   - Oral and Maxillofacial surgeons
   - Psychologists who are state certified or licensed and have doctoral or master’s level training
   - Clinical social workers who are state certified or state licensed and have master’s level training
   - Psychiatric nurse practitioners who are nationally or state certified or state licensed and have master’s level training
   - Other behavioral health care specialists who are licensed, certified or registered by the state to practice independently
   - Telemedicine practitioners who have an independent relationship with BCBSGa and who provide treatment services under the Health Benefits Plan
   - Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
   - Licensed Genetic Counselors who are licensed by the state to practice independently
   - Audiologists who are licensed, by the state to practice independently
   - Acupuncturists (non-MD/DO) who are licensed, certified or registered by the state to practice independently
   - Nurse practitioners
   - Certified nurse midwives
   - Physician assistants (as required locally)

2. Practitioners with whom we have a contractual relationship do not require credentialing when the Practitioner:

   - Practices exclusively in an inpatient setting and provides care for BCBSGa Covered Individuals only because Covered Individuals are directed to the hospital or another inpatient setting; OR
   - Practices exclusively in free-standing facilities and provides care for BCBSGa Covered Individuals only because Covered Individuals are directed to the facility.

   Examples of this type of Practitioner include, but are not limited to:
   - Pathologists
   - Radiologists
   - Anesthesiologists
   - Neonatologists
   - Emergency Room Physicians
   - Urgent Care Center Physicians
   - Urgent Care Center mid-level providers (e.g. nurse practitioners, physician assistants)
   - Hospitalists
   - Pediatric Intensive Care Specialists
   - Other Intensive Care Specialists
3. The following behavioral health practitioners are not subject to professional conduct and competence review under BCBSGa’s credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:
- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Abuse Practitioners

Note: an individual who is contracted and practices in the office setting must be credentialed when that practitioner meets criteria in section 2 of this Credentialing Policy, above.

B. Health Delivery Organizations (“HDOs”)

1. BCBSGa credentials the following Health Delivery Organizations (“HDOs”):
   - Hospitals
   - Home Health Agencies
   - Skilled Nursing Facilities (Nursing Homes)
   - Ambulatory Surgical Centers
   - Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings, including:
     - Adult Family Care/Foster Care Homes
     - Ambulatory Detox
     - Community Mental Health Centers (CMHC)
     - Crisis Stabilization Units
     - Intensive Family Intervention Services
     - Intensive Outpatient – Mental Health and/or Substance Abuse
     - Methadone Maintenance Clinics
     - Outpatient Mental Health Clinics
     - Outpatient Substance Abuse Clinics
     - Partial Hospitalization – Mental Health and/or Substance Abuse
     - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Abuse
   - Birthing Centers
   - Convenient Care Centers/Retail Health Clinics/Walk-In Clinics
   - Intermediate Care Facilities
   - Urgent Care Centers
   - Federally Qualified Health Centers (FQHC)
   - Home Infusion Therapy when not associated with another currently credentialed HDO
   - Rural Health Clinics

2. The following Health Delivery Organizations are not subject to professional conduct and competence review under BCBSGa’s credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:
   - Clinical laboratories (a CMS-issued CLIA certificate or a hospital based exemption from CLIA)
   - End Stage Renal Disease (ESRD) service providers (dialysis facilities)
   - Portable x-ray Suppliers
   - Home Infusion Therapy when associated with another currently credentialed HDO

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner’s participation in a Network or Plan Program is conducted by a peer review body, known as BCBSGa’s Credentials Committee (“CC”).

The CC will meet at least once every forty-five (45) calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. The chair must be a state or regional
lead medical director, or an BCBSGa medical director designee and the vice-chair must be a lead medical officer or an BCBSGa medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than ten external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair’s discretion. At least two of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner’s credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant’s participation, or terminate a practitioner from participation in one or more Networks or Plan Programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are Network practitioners.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate Credentialing staff, medical directors, and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes; and peer review protected information will not be shared externally.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. This right includes access to information obtained from any outside sources with the exception of references, recommendations or other peer review protected information. Providers are given written notification of these rights in communications from BCBSGa which initiates the credentialing process. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner’s credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. Upon request, applicant will be provided with the status of his or her credentialing application. Written notification of this right may be included in a variety of communications from BCBSGa which includes the letter which initiates the credentialing process, the provider web site, or Provider Manual. When such requests are received, providers will be notified whether the credentialing application has been received, how far in the process it has progressed and a reasonable date for completion and notification. All such requests will be responded to verbally unless the provider requests a written response.

BCBSGa may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

BCBSGa will not discriminate against any applicant for participation in its Networks or Plan Programs on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, BCBSGa will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the Covered Individuals to meet their needs and preferences, this information is not required in the
credentialing and re-credentialing process. Determinations as to which practitioners/HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in BCBSGa Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of BCBSGa’s Networks or Plan Programs. This application may be a state mandated form or a standard form created by or deemed acceptable by BCBSGa. For practitioners, the Council for Affordable Quality Healthcare (“CAQH”), a Universal Credentialing Datasource is utilized. CAQH built the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their web site at www.CAQH.org.

BCBSGa will verify those elements related to an applicants’ legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, BCBSGa will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>License to practice in the state(s) in which the practitioner will be treating Covered Individuals.</td>
</tr>
<tr>
<td>Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.</td>
</tr>
<tr>
<td>DEA/CDS and state controlled substance registrations</td>
</tr>
<tr>
<td>- The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Covered Individuals. Practitioners who see Covered Individuals in more than one state must have a DEA/CDS registration for each state.</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Malpractice claims history</td>
</tr>
<tr>
<td>Board certification or highest level of medical training or education</td>
</tr>
<tr>
<td>Work history</td>
</tr>
<tr>
<td>State or Federal license sanctions or limitations</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
<tr>
<td>National Practitioner Data Bank report</td>
</tr>
<tr>
<td>State Medicaid Exclusion Listing, if applicable</td>
</tr>
</tbody>
</table>

B. HDOs

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation, if applicable</td>
</tr>
<tr>
<td>License to practice, if applicable</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Medicare certification, if applicable</td>
</tr>
<tr>
<td>Department of Health Survey Results or recognized accrediting organization certification</td>
</tr>
<tr>
<td>License sanctions or limitations, if applicable</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
</tbody>
</table>
Recredentialing

The recredentialing process incorporates re-verification and the identification of changes in the practitioner’s or HDO’s licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner’s or HDO’s professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet BCBSGa credentialing standards.

During the recredentialing process, BCBSGa will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the Network within the scope of BCBSGa Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to BCBSGa for review. If the candidate meets BCBSGa screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in BCBSGa Credentialing Program Standards, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, BCBSGa may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Recredentialing of HDOs occurs every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Networks or Plan Programs must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. BCBSGa may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, BCBSGa has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General (“OIG”)
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management (“OPM”)
4. State licensing Boards/Agencies
5. Covered Individual/Customer Services Departments
6. Clinical Quality Management Department (including data regarding complaints of both a clinical and nonclinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal BCBSGa Departments
8. Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including, but not limited to: review by the Chair of BCBSGa CC, review by the BCBSGa Medical Director, referral to the CC, or termination. BCBSGa credentialing departments will report practitioners or HDOs to the appropriate authorities as required by law.
Appeals Process

BCBSGa has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of BCBSGa’s Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and BCBSGa may wish to terminate practitioners or HDOs. BCBSGa also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating participation in BCBSGa’s Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (“NPDB”). Additionally, BCBSGa will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is the intent of BCBSGa to give practitioners and HDOs the opportunity to contest a termination of the practitioner’s or HDO’s participation in one or more of BCBSGa’s Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner’s or HDO’s suspension or loss of licensure, criminal conviction, or BCBSGa’s determination that the practitioner’s or HDO’s continued participation poses an imminent risk of harm to Covered Individuals. A practitioner/HDO whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

Reporting Requirements

When BCBSGa takes a professional review action with respect to a practitioner’s or HDO’s participation in one or more of its Networks or Plan Programs, BCBSGa may have an obligation to report such to the NPDB. Once BCBSGa receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

BCBSGa Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP; and
B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Covered Individuals; and
C. Possess a current, valid, and unrestricted Drug Enforcement Agency (“DEA”) and/or Controlled Dangerous Substances (“CDS”) registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who see Covered Individuals in more than one state must have a DEA/CDS registration for each state.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

A. For MDs, DOs, DPMs, and oral and maxillofacial surgeons, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (“ABMS”), American Osteopathic Association (“AOA”), Royal College of Physicians and Surgeons of Canada (“RCPSC”), College of Family Physicians of Canada (“CFPC”), American Board of Podiatric Surgery (“ABPS”), American Board of Podiatric Medicine (“ABPM”), or American Board of Oral and Maxillofacial Surgery (“ABOMS”)) in the clinical discipline for which they are applying.
B. Individuals will be granted five years or a period of time consistent with ABMS board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.

C. Individuals with board certification from the American Board of Podiatric Medicine will be granted five years after the completion of their residency to meet this requirement. Individuals with board certification from the American Board of Foot and Ankle Surgery will be granted seven years after completion of their residency to meet this requirement.

D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
   a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC, CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of ten (10) consecutive years of clinical practice. OR
   b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. OR
   c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching Facility in BCBSGa’s Network AND the applicant’s professional activities are spent at that institution at least fifty percent (50%) of the time.

2. Practitioners meeting one of these three (3) alternative criteria (a, b, c) will be viewed as meeting all BCBSGa education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to BCBSGa review and approval. Reports submitted by delegate to BCBSGa must contain sufficient documentation to support the above alternatives, as determined by BCBSGa.

B. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (“TJC”), National Integrated Accreditation for Healthcare Organizations (“NIAHO”), an AOA accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)
   1. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
   2. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
   3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
   4. No evidence of potential material omission(s) on application;
   5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals;
   6. No current license action;
   7. No history of licensing board action in any state;
   8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report);
   9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who treat Covered Individuals in more than one state must have a valid DEA/CDS registration for each applicable state.
Initial applicants who have NO DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he/she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

a. It can be verified that this application is pending.

b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.

c. The applicant agrees to notify BCBSGa upon receipt of the required DEA/CDS registration.

d. BCBSGa will verify the appropriate DEA/CDS registration via standard sources.
   i. Initial applicants who possess a DEA/CDS registration in a state other than the state in which they will be treating Covered Individuals will be notified of the need to obtain the additional DEA/CDS registration. If the applicant has applied for additional DEA/CDS registration the credentialing process may proceed if ALL the following criteria are met:
      (a) It can be verified that this application is pending and,
      (b) The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained,
      (c) The applicant agrees to notify BCBSGa upon receipt of the required DEA/CDS registration,
      (d) BCBSGa will verify the appropriate DEA/CDS registration via standard sources; applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar day timeframe will result in termination from the Network, AND
      (e) Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;

11. No history of or current use of illegal drugs or history of or current alcoholism;

12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.

13. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable. Other gaps in work history of six to twenty-four (6 to 24) months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two (2) years.

14. No history of criminal/felony convictions or a plea of no contest;

15. A minimum of the past ten (10) years of malpractice case history is reviewed.

16. Meets Credentialing Standards for education/training for the specialty (ies) in which practitioner wants to be listed in BCBSGa’s Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;

17. No involuntary terminations from an HMO or PPO;

18. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:

a. investment or business interest in ancillary services, equipment or supplies;

b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;

c. voluntary surrender of state license related to relocation or nonuse of said license;

d. a NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.

e. non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);

f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;

g. actions taken by a hospital against a practitioner’s privileges related solely to the failure to
complete medical records in a timely fashion;

h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the Chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner's name and specialty.

B. Currently Participating Applicants (Recredentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. No evidence of potential material omission(s) on re-credentialing application;
5. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a Practitioner participates in the BCBSG’s programs or provider Network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the Practitioner will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as the BCBSG’s other credentialed provider Network(s).
6. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Covered Individuals;
7. "No current license probation;"
8. "License is unencumbered;"
9. No new history of licensing board reprimand since prior credentialing review;
10. "No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
11. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
12. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Covered Individuals needing hospitalization;
13. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
14. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
15. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
16. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
17. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
18. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
   a. investment or business interest in ancillary services, equipment or supplies;
   b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   c. voluntary surrender of state license related to relocation or nonuse of said license;
   d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
e. nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
g. actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

19. No QI data or other performance data including complaints above the set threshold.
20. Recredentialed at least every three (3) years to assess the practitioner’s continued compliance with BCBSGa standards.

*It is expected that these findings will be discovered for currently credentialed Network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for recredentialing.

C. Additional Participation Criteria and Exceptions for Behavioral Health practitioners (Non Physician) Credentialing.

1. Licensed Clinical Social Workers (“LCSW”) or other master level social work license type:
   a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (“CSWE”) or the Canadian Association on Social Work Education (“CASWE”).
   b. Program must have been accredited within three (3) years of the time the practitioner graduated.
   c. Full accreditation is required, candidacy programs will not be considered.
   d. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association (“APA”) or be regionally accredited by the Council for Higher Education Accreditation (“CHEA”). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

2. Licensed professional counselor (“LPC”) and marriage and family therapist (“MFT”) or other master level license type:
   a. Master’s or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
   c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (“CACREP”), or Commission on Accreditation for Marriage and Family Therapy Education (“COAMFTE”) listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.
   d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A Practitioner with a doctoral degree in one of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and;
   e. Licensure to practice independently.

3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and
mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three (3) years of the time of the practitioner's graduation.

b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.

c. Certification by the American Nurses Association ("ANA") in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner.

d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Covered Individuals.

4. Clinical Psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner's graduation.
   c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
   d. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology ("ABPN") or American Board of Clinical Neuropsychology ("ABCN").
   b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
   c. Clinical neuropsychologists who are not Board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training, OR
      ii. Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate), OR
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week), OR
      iv. Minimum of five (5) years experience practicing neuropsychology at least ten (10) hours per week.

6. Licensed Psychoanalysts:
   a. Applies only to Practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      i. Practitioner shall possess a master’s or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within 3 years of the time the Practitioner graduates.
      ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
a. A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.

b. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.

c. Meet examination requirements for licensure as determined by the licensing state.


- Process, requirements and Verification – Nurse Practitioners:
  i. The nurse practitioner applicant will submit the appropriate application and supporting documents as required of any other Practitioners with the exception of differing information regarding education/training and board certification.
  ii. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a Registered Nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
  iii. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
  iv. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal company procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
  v. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
    1. Certification program of the American Nurse Credentialing Center (www.nursecredentialing.org), a subsidiary of the American Nursing Association (http://www.nursingcertification.org/exam_programs.htm); or
    2. American Academy of Nurse Practitioners – Certification Program (www.aanpcertification.org); or
    3. National Certification Corporation (http://www.nccwebsite.org); or
    4. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) (http://www.pncb.org/pliststore/control/exams/ac/progs); OR
    5. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY (http://oncc.org);
      This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by the BCBSGa is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.
  vi. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken
against any hospital privileges held by the NP will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.

vii. The NP applicant will undergo the standard credentialing processes outlined in the BCBSGa’s Credentialing Policies. NPs are subject to all the requirements outlined in these Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

viii. Upon completion of the credentialing process, the NP may be listed in the BCBSGa provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

ix. NPs will be clearly identified as such:
   1. On the credentialing file;
   2. At presentation to the Credentialing Committee; and
   3. On notification to Network Services and to the provider database.

• Process, Requirements and Verifications – Certified Nurse Midwives:
  i. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other Practitioner with the exception of differing information regarding education, training and board certification.
  ii. The required educational/training will be at a minimum that required for licensure as a Registered Nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
  iii. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
  iv. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal company procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
  v. All CNM applicants will be certified by either:
      1. The National Certification Corporation for Ob/Gyn and Neonatal Nursing;
      or
      2. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.

This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by the BCBSGa is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic Credentialing Committee.

vi. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. Should the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

vii. The CNM applicant will undergo the standard credentialing process outlined in the BCBSGa’s Credentialing Policies. CNMs are subject to all the requirements of
these Credentialing Policies including (but not limited to): the requirement for Committee review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

viii. Upon completion of the credentialing process, the CNM may be listed in the BCBSGa provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

ix. CNMs will be clearly identified as such:
   1. On the credentialing file;
   2. At presentation to the Credentialing Committee; and
   3. On notification to Network Services and to the provider database.

- Process, Requirements and Verifications – Physician’s Assistants (PA):
  i. The PA applicant will submit the appropriate application and supporting documents as required of any other Practitioners with the exception of differing information regarding education/training and board certification.
  ii. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
  iii. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
  iv. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal company procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
  v. All PA applicants will be certified by the National Commission on Certification of Physician’s Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by the BCBSGa is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to geographic Credentialing Policy #8 and submitted for individual review by the Credentialing Committee.
  vi. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
  vii. The PA applicant will undergo the standard credentialing process outlined in the BCBSGa’s Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): Committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
  viii. Upon completion of the credentialing process, the PA may be listed in the BCBSGa provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
  ix. PA’s will be clearly identified such:
      1. On the credentialing file;
      2. At presentation to the Credentialing Committee; and
      3. On notification to Network Services and to the provider database.

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, BCBSGa may evaluate the most recent site survey by Medicare, the appropriate state
oversight agency, or site survey performed by a designated independent external entity within the past 36 months. Non-accredited HDOs are subject to individual review by the CC and will be considered for Covered Individual access need only when the CC review indicates compliance with BCBSGa standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three (3) years to assess the HDO’s continued compliance with BCBSGa standards.

A. General Criteria for HDOs:
1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Covered Individuals. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in the BCBSGa’s programs or provider Network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as the BCBSGa’s other credentialed provider Network(s).
4. Liability insurance acceptable to BCBSGa.
5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if BCBSGa’s quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

**HDO Type and BCBSGa Approved Accrediting Agent(s)**

<table>
<thead>
<tr>
<th>Medical Facilities</th>
<th>Acceptable Accrediting Agencies</th>
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</thead>
<tbody>
<tr>
<td><strong>Facility Type (Medical Care)</strong></td>
<td></td>
</tr>
<tr>
<td>Acute Care Hospital</td>
<td>CIQH, CTEAM, DNV/NIAHO, HFAP, TJC</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers</td>
<td>AAAASF, AAAHC, APSF, HFAP, IMQ, TJC</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>AAAHC, CABC</td>
</tr>
<tr>
<td>Clinical Laboratories</td>
<td>CLIA, COLA</td>
</tr>
<tr>
<td>Convenient Care Centers (CCCs)/Retail Health Clinics (RHC)</td>
<td>DNV/NIAHO, UCAOA, TJC</td>
</tr>
<tr>
<td>Dialysis Center</td>
<td>CMS Certification, TJC</td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC)</td>
<td>AAAHC</td>
</tr>
<tr>
<td>Free-Standing Surgical Centers</td>
<td>AAAASF, APSF, HFAP, IMQ, TJC</td>
</tr>
<tr>
<td>Home Health Care Agencies (HHA)</td>
<td>ACHC, CHAP, CTEAM, DNV/NIAHO, TJC</td>
</tr>
<tr>
<td>Home Infusion Therapy (HIT)</td>
<td>ACHC, CHAP, CTEAM, HQAA, TJC</td>
</tr>
<tr>
<td>Hospice</td>
<td>ACHC, CHAP, TJC</td>
</tr>
<tr>
<td>Intermediate Care Facilities</td>
<td>CTEAM</td>
</tr>
<tr>
<td>Portable x-ray Suppliers</td>
<td>FDA Certification</td>
</tr>
<tr>
<td>Skilled Nursing Facilities/Nursing Homes</td>
<td>BOC INT'L, CARF, TJC</td>
</tr>
<tr>
<td>Rural Health Clinic (RHC)</td>
<td>AAAASF, CTEAM, TJC</td>
</tr>
<tr>
<td>Urgent Care Center (UCC)</td>
<td>AAAHC, IMQ, TJC, UCAOA</td>
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<thead>
<tr>
<th>Behavioral Health</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility Type (Behavioral Health Care)</strong></td>
<td></td>
</tr>
<tr>
<td>Acute Care Hospital—Psychiatric Disorders</td>
<td>CTEAM, DNV/NIAHO, TJC, HFAP</td>
</tr>
<tr>
<td>Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation</td>
<td>HFAP, NIAHO, TJC</td>
</tr>
<tr>
<td>Adult Family Care Homes (AFCH)</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Adult Foster Care</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Community Mental Health Centers (CMHC)</td>
<td>AAAHC, CARF, CHAP, COA, HFAP, TJC</td>
</tr>
<tr>
<td>Crisis Stabilization Unit</td>
<td>TJC</td>
</tr>
<tr>
<td>Intensive Family Intervention Services</td>
<td>CARF</td>
</tr>
<tr>
<td>Intensive Outpatient – Mental Health and/or Substance Abuse</td>
<td>ACHC, DNV/NIAHO, TJC, COA, CARF</td>
</tr>
<tr>
<td>Outpatient Mental Health Clinic</td>
<td>HFAP, TJC, CARF, CHAP, COA</td>
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</tbody>
</table>
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse  CARF, DNV/NIAHO, HFAP, TJC, for programs associated with an acute care facility or Residential Treatment Facilities.

Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse  CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

<table>
<thead>
<tr>
<th>Facility Type (Behavioral Health Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Hospital – Detoxification Only Facilities</td>
<td>DNV/NIAHO, HFAP, TJC</td>
</tr>
<tr>
<td>Behavioral Health Ambulatory Detox</td>
<td>CARF, TJC</td>
</tr>
<tr>
<td>Methadone Maintenance Clinic</td>
<td>CARF, TJC</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Clinics</td>
<td>CARF, COA, TJC</td>
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</tbody>
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Quality Improvement Program Overview

“Together, we are transforming health care with trusted and caring solutions.” We believe health care is local, and BCBSGa has the strong local presence required to understand and meet customer needs. Our Plan is well positioned to deliver what customers want: innovative, choice-based products; distinctive service; simplified transactions; and better access to information for quality care. Our local Plan presence and broad expertise create opportunities for collaborative programs that reward Providers and Facilities for clinical quality and excellence. Providers and Facilities must cooperate with Quality Improvement activities. Our commitment to health improvement and care management provides added value to customers and health care professionals – helping improve both health and health care costs for those BCBSGa serves. BCBSGa takes a leadership role to improve the health of communities, and is helping to address some of health care’s most pressing issues. The Quality Improvement (“QI”) Program Description defines the quality infrastructure that supports BCBSGa’s QI strategies.

- The QI Program Description establishes QI Program governance, scope, goals, measurable objectives, structure, and responsibilities encompassing the quality of medical and behavioral health care and services provided to Covered Individuals.
- Annually, a QI Work Plan is developed and implemented which reflects ongoing progress made on QI activities during the year. The QI Work Plan includes the Plan’s approach to patient safety and improving medical and behavioral health care: quality of clinical care, safety of clinical care, and quality of service.
- The QI Evaluation assesses outcomes of the Plan’s medical and behavioral health care programs, processes and activities. The QI Evaluation also evaluates how the QI Program goals and objectives were met.

Information on BCBSGa’s QI Program and most current outcomes can be found on BCBSGa.com. Select Menu, and then under the Support heading select the Providers link. Select the Health & Wellness tab at the top of the page. Select Quality Improvements and Standards from the drop down list, and select Quality Improvement Program.

Goals and Objectives

The following QI Program goals and objectives have been adopted to support BCBSGa’s vision and values and to promote continuous improvement in quality care, patient safety, and quality of service to Covered Individuals, Providers and Facilities:
- To develop and maintain a well-integrated system to continuously identify, measure, assess, and help improve clinical and service quality outcomes through standardized and collaborative activities.
- To respond to the needs and expectations of internal and external customers by evaluating performance and taking action relative to meeting those needs and expectations including compliance with regulatory requirements, accreditation standards, and policies and procedures.
• To promote processes that reduce medical errors and improve patient safety by implementing member-focused, practitioner/provider initiatives, and safety initiatives.

• To identify the educational needs of Covered Individuals, practitioners, and other health care professionals including behavioral health practitioners and providers.

• To identify health disparities trends for Covered Individuals based on key clinical quality metrics, evidence-based research, or Covered Individual experience metrics to inform response needs with appropriate culturally and linguistically enhanced services.

• To help maximize health status, improve health outcomes, and reduce health care costs of Covered Individuals through effective Case Management and Disease Management programs addressing complex care needs.

As part of the QI Program, initiatives in these major areas include, but are not limited to:

**Quality and Safety of Clinical Care**

*Chronic Disease and Prevention:* BCBSGa focuses on Covered Individual and/or Provider/Facility outreach for chronic conditions like asthma, heart disease, diabetes, and COPD, and for preventive health services such as immunizations and cancer screenings. Improvements in these areas result in improved clinical measures such as HEDIS® (Healthcare Effectiveness Data and Information Set).¹

*Behavioral Health Case Management:* A program designed to provide a comprehensive and integrated approach to early identification, appropriate treatment, intensive case management, and individualized recovery support for members with complex, behavioral health conditions who are at risk for negative outcomes and high costs.

*Community Health:* BCBSGa addresses public health priorities including behavioral health, cancer, diabetes, maternal/child health, obesity, patient safety, and smoking cessation by collaborating with key stakeholders in the industry. These focus areas are aligned with the BCBSGa Foundation’s goals, measured through State Health Index (SHI) to assess performance trend and improvement opportunities. Programs recently developed include:

  − Web-based resources for managers to support employees’ healthy return to work after cancer treatment. (*Work Plan Transitions for People Touched by Cancer*)
  − Smoking Cessation Program that helps to reduce smoking, as well as, premature and underweight births. (*Baby & Me - Tobacco Free*)
  − Digital magazine featuring free resources available to all people touched by cancer. (*Stronger Together*)
  − Diabetes program that promotes successful aging through lifelong learning, healthy living and social engagement in collaboration with the National Council on Aging (NCOA), the Oasis Institute, and YMCA. (*Better Choices Better Health*)

*Disease Management:* The ConditionCare programs are designed to help maximize health status, improve health outcomes, and reduce health care costs of Covered Individuals diagnosed with Asthma (pediatric and adult), Diabetes (Type 1 and Type 2, pediatric and adult), Coronary Artery Disease (CAD), Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD). These disease management programs were created and developed based on recent versions of nationally accepted evidence-based clinical practice guidelines. These guidelines are reviewed at least every two (2) years, and program interventions and protocols are updated accordingly.

*Health & Wellness:* Programs offer a seamless integration of preventive care, wellness, case management, and care coordination to meet the needs of Covered Individuals along the complete continuum of care. Programs include: MyHealth Coach (MHC), MyHealth Advantage (MHA), Neonatal Intensive Care Program, Worksite Wellness, and Healthy Lifestyles.

**Service Quality**
BCBSGa periodically surveys its Covered Individuals, evaluates service performance and quality of care, and strives to provide excellent service to Covered Individuals, Providers and Facilities. BCBSGa analyzes trends to identify service opportunities, and recommends appropriate activities to address root causes.

**Patient Safety**

Patient safety is critical to the delivery of quality health care by Providers and Facilities. Our goal is to work with physicians, hospitals and other health care Providers and Facilities to promote and encourage patient safety and to help reduce medical errors through the use of guidelines, outcomes-based medicine, processes, and systems aimed at reducing errors. Specifically, we will provide support through collaborative efforts with physicians and hospitals for the medical and behavioral health care they provide to Covered Individuals that includes incentives based on quality metrics, public reporting of safety information to employers, Providers, Facilities, and Covered Individuals to emphasize the importance of programs to reduce medical errors, and empowerment of consumers with information to make informed choices. Improvement in patient safety is dependent upon not only patient needs, but also upon informed patients and the global health care community’s demand and attention to clinical outcomes-based practices.

1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

**Quality-In-Sights®: Hospital Incentive Program (Q-HIPSM)**

The Quality-In-Sights®: Hospital Incentive Program (Q-HIP®) is our performance-based reimbursement program for hospitals. The mission of Q-HIP is to help improve patient outcomes in a hospital setting and promote health care value by financially rewarding hospitals for practicing evidence-based medicine and implementing best practices. Q-HIP strives to promote improvement in health care quality and to raise the bar by moving the bell shaped “quality curve” to the right towards high performance.

Q-HIP measures are credible, valid, and reliable because they are based on measures developed and endorsed by national organizations which may include:

- American College of Cardiology (ACC)
- Center for Medicare and Medicaid Services (CMS)
- Institute for Healthcare Improvement (IHI)
- National Quality Forum (NQF)
- The Joint Commission (JC)
- The Society of Thoracic Surgeons (STS)

In order to align Q-HIP goals with national performance thresholds, the Q-HIP benchmarks and targets are based on national datasets such as the Centers for Medicare and Medicaid Services’ Hospital Compare database. The measures can be tracked and compared within and among hospital[s] for all patient data – regardless of health plan carrier.

Annual meetings are held with participating hospitals from across the country, offering participants an opportunity to share feedback regarding new metrics and initiatives. Additionally, a National Advisory Panel on Value Solutions (“NAPVS”) was established in 2009 to provide input during the scorecard development process. The NAPVS is made up of patient safety and quality leaders from health systems and academic medical centers from across the country and offers valuable advice and guidance as new measures are evaluated for inclusion in the program.
Participating hospitals are required to provide BCBSGa with data on measures outlined in the Q-HIP Manual. Q-HIP measures are based on commonly accepted indicators of hospitals’ quality of care. Participating hospitals will receive a copy of their individual scorecard which shows their performance on the Q-HIP measures.

**Quality-In-Sights®: Primary Care Incentive Program**

The Quality-In-Sights Primary Care Incentive Program rewards physician practices for meeting or exceeding established targets related to quality, patient safety, applicable external recognition programs, and adoption of technology.

**Specialties included in the Quality-In-Sights Primary Care Incentive Program**

The program is open to Provider and Facilities who specialize in Family Medicine, General Practice, Internal Medicine and/or Pediatrics as their designated primary specialty, who meet eligibility requirements and who provide primary care services to Covered Individuals of BCBSGa and BCBSGa enrolled in a HMO, Point of Service or PPO Health Benefit Plan product.

**Performance Data**

**Provider/Facility Performance Data** means compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual healthcare practitioner, such as a physician, or a healthcare organization, such as a hospital. Common examples of performance data would include the Healthcare Effectiveness Data and Information Set (HEDIS) quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF). Provider/Facility Performance Data may be used for multiple Plan programs and initiatives, including but not limited to:

- **Reward Programs** – Pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie Provider or Facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.

- **Recognition Programs** – Programs designed to transparently identify high value Providers and Facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

**Clinical Practice Guidelines**

BCBSGa considers clinical practice guidelines to be an important component of health care. BCBSGa adopts nationally recognized clinical practice guidelines, and encourages physicians to utilize these guidelines to improve the health of our Covered Individuals. Several national organizations such as, National Heart, Lung and Blood Institute, American Diabetes Association and the American Heart Association, produce guidelines for asthma, diabetes, hypertension, and other conditions. The guidelines, which BCBSGa uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines through the Internet. To access the guidelines, go to the “Provider” home page at bcbsga.com. Click on the “Provider”
link at the top of the new landing page. On the Provider Home page, under the Health and Wellness tab (on the blue toolbar) select or scroll to the practice guidelines, then select the link titled Clinical Practice Guidelines.

With respect to the issue of coverage, each Covered Individual should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersedes the clinical practice guidelines.

Preventive Health Guidelines

BCBSGa considers prevention an important component of health care. BCBSGa develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage physicians to utilize these guidelines to improve the health of our Covered Individuals.

The current guidelines are available on our website. To access the guidelines, go to the “Provider” home page at bcbsga.com. Click on the “Provider” link at the top of the new landing page. On the Provider Home page, under the Health and Wellness tab (on the blue toolbar) select or scroll to the practice guidelines, then select the link titled Clinical Practice Guidelines.

With respect to the issue of coverage, each Covered Individual should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersedes the preventive health guidelines.

Covered Individual Safety

Leapfrog Group

The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing power to alert America’s health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog works with its employer members to encourage transparency and easy access to health care information as well as rewards for hospitals that have a proven record of high quality care.

The Leapfrog Group aims to:
• Reduce preventable medical mistakes and improve the quality and affordability of health care.
• Encourage health providers to publicly report their quality and outcomes so that consumers and purchasing organizations can make informed health care choices.
• Reward doctors and hospitals for improving the quality, safety and affordability of health care.
• Help consumers reap the benefits of making smart health care decisions.
• Network hospitals are encouraged to join the Leapfrog Group and implement policies to reduce medical errors and improve Covered Individual safety. In 2006, there was a 30% increase in HMO/POS participation/response to survey and a 20% increase in the PPO participation/response to survey. There was a significant increase in the “Evidenced Based Hospital Referral” (EHR) leap and 100% of facilities attained the “Fully implemented” rating for “National Quality Forum-Endorsed Safe Practices” (NQF-S) leap.

If your hospital has not completed the survey, you can do so by logging on to the Leapfrog Group Web site at www.leapfroggroup.org.

Partnership for Health and Accountability
Georgia’s Partnership for Health and Accountability ("PHA"), initiated with the funding of Georgia Hospital Association, an Association of Hospitals and Health Systems, recognizes Covered Individual safety as its top priority and describes the elements that support a culture of safety in healthcare organizations. Among these are a pervasive commitment to Covered Individual safety, open communication, a blame-free environment, and the importance of safety design in preventing future errors. Acknowledging that success in creating a culture of safety requires the commitment of both organizational leadership and frontline health care workers; PHA stresses the critical role of physicians and employees in the process.

PHA brings together the healthcare field with agencies and individuals to ensure quality and safety in healthy communities. PHA assists in strengthening collaboration between providers, community members, and other stakeholders by providing education and data-driven tools to facilitate improvement.

BCBSGa serves on the PHA Advisory Council, whose role is to provide advice, develop consensus and make recommendations on major issues and communicate that information to their constituent groups and others that affect health policy throughout the state.

Health Insurance Portability & Accountability Act (HIPAA)

BCBSGa is HIPAA compliant and any request for information or records from a provider is made within the boundaries of HIPAA regulations.

Additional Information on BCBSGa Quality Improvement Programs

Additional information on BCBSGa’s Quality Improvement programs can be found on BCBSGa.com. Go to BCBSGa.com, and select the Providers link at the top of the landing page. On the Provider Home page, select Quality Improvement and Standards.

HEDIS® Overview of HEDIS®

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. BCBSGa’s HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Record requests to Provider offices begin in early February and BCBSGa requests that the records be returned within 5 business days to allow time to abstract the records and request additional information from other Providers, if needed. Health plans use HEDIS data to encourage their contracted providers to make improvements in the quality of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs. More information on HEDIS can be found online at BCBSGa.com. Select Menu, and then under the Support heading select the Providers link. Choose your state from the drop down list and enter. Select the Health & Wellness tab at the top of the page. Select Quality Improvement and Standards from the drop down list, and then scroll down to HEDIS Information.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

CAHPS

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from BCBSGa’s Covered Individuals about their experiences with BCBSGa’s health plans in the past year. This includes the Covered Individual’s access to medical care and the quality of the services provided by BCBSGa’s network of Providers. BCBSGa analyzes this feedback to identify issues causing Covered Individual dissatisfaction and works to develop effective interventions to address them. BCBSGa takes this survey feedback very seriously.
Health Plans report survey results to NCQA, which uses these survey results for the annual accreditation status determinations and to create National benchmarks for care and service. Health Plans also use CAHPS® survey data for internal quality improvement purposes.

Results of these surveys are shared with Providers annually via Network Update, our provider newsletter, found on BCBSGa’s Provider website at BCBSGa.com, so they have an opportunity to learn how BCBSGa Covered Individuals feel about the services provided. BCBSGa encourages Providers to assess their own practice to identify opportunities to improve patients’ access to care and improve interpersonal skills to make the patient care experience a more positive one.

© CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Member Health & Wellness Programs

BCBSGa seeks to improve the lives of the Covered Individuals we serve. BCBSGa provides a unique blend of health and wellness programs to help Covered Individuals reach their total well-being goals. A quick overview of the programs and services BCBSGa offers is available by going to the BCBSGa.com. Select Menu, and then under the Support heading select the Providers link in the center of the page.

Cultural Diversity

Cultural Diversity Overview

BCBSGa identifies health disparity trends for Covered Individuals based on key clinical quality metrics, evidence-based research, or member experience metrics and conducts research on best practices to help educate Providers, Facilities and others about how to reduce health disparities. Specifically, BCBSGa:

1. Monitors the quality of health care for actionable health and health care disparities trends
   a. Identifies clinical and geographic areas exhibiting health and health care disparities and designs appropriate interventions to help close the disparity gaps
   b. Establishes baseline data and measures/evaluates the results of program interventions
   c. Supports Covered Individual access to equitable treatment, standards of care and services based on their Plan benefits

2. Promotes Culturally and Linguistically Appropriate Services (“CLAS”)
   a. Offers education, tools and subject matter expertise to Providers and Facilities that may help them achieve the shared goal of providing quality care and service equally to their patients
   b. Facilitates cultural competency of BCBSGa associates to meet the Covered Individuals’ needs for culturally sensitive, linguistically appropriate care and service
   c. Offers education, tools and subject matter expertise to Covered Individuals that may help them improve their health literacy, allowing better communication with their doctors and BCBSGa about their health care and service

3. Develops programs to help improve health status and outcomes
a. Promotes consumer-centered care that addresses the Covered Individuals' values, needs and preferences in reaching optimal health care and outcomes standards

b. Supports communities in which BCBSGa does business with cultural and linguistic programs and services

c. Collaborates with other industry and government efforts to help reduce and eliminate health disparities

BCBSGa strives to promote the Department of Health and Human Services Office of Minority Health’s National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS standards).  [https://www.thinkculturalhealth.hhs.gov/clas/standards](https://www.thinkculturalhealth.hhs.gov/clas/standards)

**Learning Opportunities**

BCBSGa recognizes that Providers and Facilities can encounter challenges when delivering health care services to a diverse population. Those challenges arise when Providers and Facilities need to cross a cultural divide to treat patients who may have different behaviors, attitudes, and beliefs concerning health care.

- In response, BCBSGa offers online educational experiences for providers – e.g., “Moving Toward Equity in Asthma Care.”
- Built upon extensive research and data analytics, the experience offers 1 hour of Continuing Medical Education (“CME”) credit through the American Academy of Family Physicians, and includes scenarios that fulfill the following learning objectives:
  - Describe common racial and ethnic asthma disparities – and their effects on diverse patients’ ability to successfully control their asthma.
  - Describe ways providers may unknowingly contribute to poor asthma care for diverse populations.
  - Explain ways providers can improve the quality of asthma care to enhance outcomes among African Americans, Hispanic and Asian patients.
  - Explain the importance of using spirometry to assess the severity of asthma accurately.
  - Explain the concept of “unconscious bias.”
  - A “Resources” section contains additional information on asthma disparities, as well as culturally relevant asthma materials to print and share with diverse patients.
  - The experience was developed in an effort to address the substantial gaps in asthma care and outcomes for diverse populations.

Primary Audiences include: Physicians (Family Practice, Pediatrician, Pulmonologist, Allergist Immunologist), Nurse Practitioners, Registered Nurse (RN), Licensed Vocational Nurse (LVN), and Licensed Practical Nurse (LPN).

The course is available at [www.BCBSGa.com/asthma.equity](http://www.BCBSGa.com/asthma.equity) (on demand) and is accessible from any mobile device, laptop, or desktop computer. Users must have access to Internet Explorer (9 or later), Google Chrome (38 or later), Safari (5 or later), Mozilla Firefox (32 or later).

In addition, a Toolkit, called “Caring for Diverse Populations,” was developed to give Providers’ and Facilities specific tools for breaking through cultural and language barriers in an effort to better communicate with their patients. Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater awareness of cultural sensitivities can open the door to the kind of interaction that makes treatment plans most effective: Has the individual been raised in a culture that frowns upon direct eye contact or receiving medical treatment from a member of the opposite sex? Is the individual self-conscious about his or her ability to read instructions?
This toolkit gives Providers and Facilities the information needed to answer those questions and continue building trust. It will enhance Providers and Facilities’ ability to communicate with ease, talking to a wide range of people about a variety of culturally sensitive topics. And it offers cultural and linguistic training to office staff so that all aspects of an office visit can go smoothly.

We strongly encourage Providers and Facilities to access the complete toolkit:

http://bridginghealthcaregaps.com/

The toolkit contents are organized into the following sections:

**Improving Communications with a Diverse Patient Base**
- Encounter tips for Providers and their clinical staff
- A memory aid to assist with patient interviews
- Help in identifying literacy problems

**Tools and Training for Your Office in Caring for a Diverse Patient Base**
- Interview guide for hiring clinical staff who have an awareness of cultural competency issues
- Availability of Medical Consumerism training for health educators to share with patients

**Resources to Communicate Across Language Barriers**
- Tips for locating and working with interpreters
- Common signs and common sentences in many languages
- Language identification flashcards
- Language skill self-assessment tools

**Primer on How Cultural Background Impacts Health Care Delivery**
- Tips for talking with people across cultures about a variety of culturally sensitive topics
- Information about health care beliefs of different cultural backgrounds

**Regulations and Standards for Cultural and Linguistic Services**
- Identifies important legislation impacting cultural and linguistic services, including a summary of the “Culturally and Linguistically Appropriate Services” (“CLAS”) standards which serve as a guide on how to meet these requirements.

**Resources for Cultural and Linguistic Services**
- A bibliography of print and Internet resources for conducting an assessment of the cultural and linguistic needs of a practice’s patient population
- Staff and physician cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for limited English proficiency

The toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort ("ICE") Cultural and Linguistics Workgroup, a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies, and accrediting bodies working collaboratively to improve health care regulatory compliance through public education. More information on the ICE Workgroup may be obtained on the ICE Workgroup website: http://www.iceforhealth.org/home.asp

**Cultural competency training available on BCBSGa.com**

**Creating an LGBT-Friendly Practice: Bridging Multicultural Health Care Gaps**

What you may not know about your Lesbian, Gay, Bisexual, or Transgender (“LGBT”) patients may be putting their health at risk. Studies have shown that many LGBT patients fear they will be treated differently in health care settings and that this fear of discrimination prevents them from seeking primary care. BCBSGa joins you in striving for the best clinical outcomes for everyone, including LGBT populations. That’s why BCBSGa has
created an online experience that provides strategies, tools, and resources to Providers and Facilities interested in attracting or maintaining an LGBT patient panel. Hopefully, as a result of increasing LGBT-friendly practices, we will see an increase in primary care and prevention among LGBT patients. Like you, BCBSGa strives to meet the needs of our diverse membership and upholds access to consistently high quality standards across our networks. We believe that by offering our Providers and Facilities these types of experiences, we can help keep all our Covered Individuals healthy. In addition, this online experience reinforces our commitment to equality for our LGBT Covered Individuals as referenced in our Provider and Facility contractual non-discrimination provisions.

Visit the provider pages online at [www.BCBSGa.com/lgbt](http://www.BCBSGa.com/lgbt) for free 24/7 access to the experience – either via your computer, tablet or smartphone. You will gain an increased understanding of how to create an LGBT-friendly practice, which may improve the health of your patients. Approved for 1 AAFP Prescribed credit, which is equivalent to AMA PRA Category 1 Credit™.

**Medical Records Standards**

BCBSGa recognizes the importance of medical record documentation in the delivery and coordination of quality care. BCBSGa has medical record standards that require Providers and Facilities to maintain medical records in a manner that is current, organized, and facilitates effective and confidential medical record review for quality purposes.

For more information on Medical Record standards, please go to the “Provider” home page at bcbsga.com Click on the “Provider” link at the top of the new landing page. On the Provider home page, choose Quality Improvement and Standards, and then scroll down to “Medical Record Review”.

**Centers of Medical Excellence (CME)**

BCBSGa currently offers access to Centers of Medical Excellence (“CME”) programs in solid organ and blood/marrow transplants, bariatric surgery, cardiac care, complex and rare cancers, maternity, spine surgery, and knee/hip replacement surgery. As much of the demand for CME programs has come from National Accounts, most of our programs are developed in partnership with the Blue Cross and Blue Shield Association (“BCBSA”) and other Blue plans to ensure adequate geographic coverage. The BCBSA refers to its designated CME hospitals as Blue Distinction Centers for Specialty Care™ (“BDC”). Using objective information and input from the medical community, the BCBSA has designated hospitals as Blue Distinction Centers that are proven to outperform their peers in the areas that matter to you – quality, safety and, in the case of Blue Distinction Centers+, efficiency.

For transplants, Covered Individuals also have access to the BCBSGa Centers of Medical Excellence Transplant Network. The CME designation is awarded to qualified programs by a panel of national experts currently practicing in the fields of solid organ or marrow transplantation representing transplant centers across the country. Each Center must meet BCBSGa’s CME participation requirements and is selected through a rigorous evaluation of clinical data that provides insight into the Facility’s structures, processes, and outcomes of care. Current designations include the following transplants: autologous/allogeneic bone marrow/stem cell, heart, lung, combination heart/lung, liver, kidney, simultaneous kidney/pancreas and pancreas.

For both the BDC and BCBSGa CME programs, selection criteria are designed to evaluate overall quality, providing a comprehensive view of how the facility delivers specialty care. More information on our programs can be accessed online at [BCBSGa.com](http://www.BCBSGa.com). Select Menu, and then under the Support heading, select the Providers link. Choose your state from the drop down list and enter. Select the Health & Wellness tab at the top of the page, and select **Centers for Medical Excellence**.
Transplant

- Blue Distinction Centers for Transplant™ ("BDCT") launched in 2006.
- More than 122,276 people in the United States were registered for organ donations from one of the nation's more than 800 transplant programs in 2015.
- Blue Distinction Centers and Blue Distinction Centers+ for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each facility meets stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations**, including the Center for International Blood and Marrow Transplant Research ("CIBMTR"), the Scientific Registry of Transplant Recipients ("SRTR"), and the Foundation for the Accreditation of Cellular Therapy ("FACT"), and is subject to periodic re-evaluation as criteria continue to evolve. Both Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.
- Hospitals receiving the Blue Distinction Center+ for Transplants designation have met the Blue Distinction Centers' standards for quality while also demonstrating better cost-efficiency relative to their peers.
- The BCBSGa CME Transplant Network is a wrap-around network to the BDCT program and offers Covered Individuals access to an additional 60 transplant facilities. When BDCT and BCBSGa CME are combined, Covered Individuals have access to 300 transplant specific programs for heart, lung, combined heart/lung, liver, pancreas, combined kidney/pancreas, and bone marrow/stem cell transplant.

Cardiac Care

- Blue Distinction Centers for Cardiac Care® launched in January 2006.
- According to the Centers for Disease Control and Prevention, the number of adults with a diagnosis of heart disease is 27.6 million, and the percent of adults with diagnosed heart disease is 11.5%. Heart Disease is the #1 Cause of death in the United States.
- Research shows that Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ are also 20 percent more cost-efficient than non-designated hospitals for those same cardiac procedures.
- Blue Distinction Centers and Blue Distinction Centers+ for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery).

Bariatric Surgery

- Blue Distinction Centers for Bariatric Surgery® launched in 2008
- According to the National Center for Health Statistics report released in November 2015: Prevalence of Obesity among Adults and Youth has grown to more than one-third (36.5%) of U.S. adults which have been diagnosed with obesity, and 32.3% for young adults aged 20-39. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, which are some
of the leading causes of preventable death.

- Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery ("ASMBS") and the American College of Surgeons ("ACS"), and is subject to periodic re-evaluation as criteria continue to evolve.

- The 2017 Blue Distinction Centers for Bariatric Surgery program uses updated Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program ("MBSAQIP") accreditation levels, which focus on site of service. With this design change, each facility can apply to achieve the BDC or BDC+ designation, as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center ("ASC").

Complex and Rare Cancers

- Blue Distinction Centers for Complex and Rare Cancers® launched in 2008.

- The Blue Distinction Centers for Complex and Rare Cancers program offers access to designated facilities for the treatment of 13 complex and rare cancers including esophageal cancer, pancreatic cancer, liver cancer, rectal cancer, gastric cancer, bone tumors, soft tissue sarcomas, brain tumors – primary, non-metastatic malignancies, bladder cancer, thyroid cancer – medullary or anaplastic, ocular melanoma, and head and neck cancers.

- Complex and Rare Cancers comprise approximately 15 percent of new cancer cases each year. The Blue Distinction Centers for Complex and Rare Cancers program evaluates facilities on patient assessment, treatment planning, complex inpatient care and major surgical treatments for adults; all delivered by teams with distinguished expertise and subspecialty training for complex and rare cancers. The Blue Cross and Blue Shield Association recognizes that the majority of patients’ multidisciplinary treatment may be best accomplished by integrating the expertise available in a Blue Distinction Center with locally available treatment resources, especially for outpatient chemotherapy and radiotherapy, based on individual circumstances and patient preference. Optimal support of a patient’s comprehensive cancer care needs may be achieved by coordination of care between the patient and their family, local physicians, the Blue Distinction Center and their local Blue Cross and Blue Shield Plan.

- The Blue Distinction Centers for Complex and Rare Cancers program was developed in collaboration with the National Comprehensive Cancer Network ("NCCN"), with input from a panel of nationally recognized clinical experts and utilizing published evidence, where available.

Spine Surgery


- Studies confirm that as many as eight out of 10 Americans suffer from some sort of back pain. Many ways to treat back pain are available, and your doctor can guide you toward the most appropriate recommendation for your situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option.

- Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than non-designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.

- Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.
To date, we have designated hospitals in the majority of states across the U.S.

**Knee and Hip Replacement**

- Blue Distinction Centers for Knee and Hip Replacement™ launched in November 2009.
- Blue Distinction Centers and Blue Distinction Centers+ for Knee and Hip Replacement provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement surgeries.

**Maternity Care**

- Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care launched in 2016 and offers access to healthcare facilities with demonstrated expertise and a commitment to quality care during the delivery episode of care, which includes both vaginal and cesarean section delivery.
- The Maternity Care designation uses publicly available data from Hospital Compare data which includes the Early Elective Delivery (PC-01) and elected patient experience measures at the facility level from Hospital Consumer Assessment of Healthcare Providers and Systems (“HCAHPS”).

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### Covered Individual Grievance and Appeal Process

#### Covered Individual Complaints about Service

We hope that your BCBSGa Covered Individuals will always be satisfied with the level of service provided to them and their families. We realize, however, that there may be times when problems arise and miscommunications occur which lead to feelings of dissatisfaction. Your BCBSGa Covered Individuals have the right to express dissatisfaction and to expect unbiased resolution of issues.

#### Covered Individual Appeals Process

The following process has been established to ensure that we give our fullest attention to Covered Individual concerns. The following steps should be used if a Covered Individual is displeased with any aspect of services rendered:

1. Fax the complaint, with supporting documentation, to (877) 868-7950 or call Customer Care at (800) 441-CARE from 7 AM – 7 PM on weekdays.
2. If the Covered Individual remains dissatisfied, they may file a formal complaint, preferably in writing. Our Customer Care Associates, who can be reached at the number above, will provide instructions for further review.
3. Depending on the nature of the complaint, the Covered Individual will be offered the right to appeal our decision. At the conclusion of this formalized review, we will mail a written response to your Covered Individual, which will hopefully bring the matter to a satisfactory conclusion. We strive to complete all Covered Individual appeals, with a written response within sixty (60) calendar days.

**Please note:** Under certain circumstances, an office site review may be required during the course of reviewing a Covered Individual complaint regarding quality of the provider office.
Provider Complaint and Appeals Process

Provider Complaint and Appeal Decisions

The Provider complaint process establishes the structure and processes by which BCBSGa Provider or Facility can get questions answered or pursue resolution of issues related to Claims payment, provider administration issues, and utilization management decisions. In order to ensure that questions and concerns are addressed promptly, we ask you to follow the process outlined below.

1. **Claims Payment Issues** – Please remember that generally, if a Network Provider or Facility does not dispute or question a specific payment within three hundred and sixty-five (365) days of receipt of payment, he/she shall be deemed to have waived all rights to dispute said payment.

<table>
<thead>
<tr>
<th>STEP ONE</th>
<th>Begin by using the self-service tools that are available at <a href="http://www.bcbsga.com">www.bcbsga.com</a>. These tools can provide you with payment and bundling logic, line-level detail, and member information such as eligibility, benefits and cost shares.</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEP TWO</td>
<td>If you have remaining questions, you can call Customer Service at the phone number on the back of the Member’s ID card. If Customer Service is unable to assist you, you may request to speak with a Customer Service supervisor.</td>
</tr>
<tr>
<td>STEP THREE</td>
<td>If the Customer Service supervisor is unable to speak with you immediately, you will receive a call back within two business days. Customer Service will provide you with a reference number for your inquiry. Kindly use this number when referring to your inquiry.</td>
</tr>
</tbody>
</table>

2. **Provider Administration Issues**. These issues include:
   a. Questions about your Provider Agreement
   b. Requests for Fee Schedules
   c. Information about how to register and access the BCBSGa self-service tools
   d. Training and Education
   e. Questions about products or programs offered by BCBSGa

   | STEP ONE | Call your Provider Representative. If you do not know the name of your Provider Representative or how to reach him/her, you can call 1-888-706-3475 for further guidance. |

3. **Appeal of Utilization Management Decisions**. These include but are not limited to:
   a. Determination that services did not meet Medical Necessity
   b. Denial of a portion or all of a hospital stay
   c. Denial for lack of preauthorization

<table>
<thead>
<tr>
<th>STEP ONE</th>
<th>Provider must submit a formal request for an appeal in writing. The Appeal must be accompanied by all supporting documentation for review.</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEP TWO</td>
<td>If the appeal is 10 pages or less, you can fax it to Provider Appeals at 888-859-3046. For larger documents, please mail to BCBSGa Attn: Provider Appeals P.O. Box105449 Atlanta, GA 30348-5449</td>
</tr>
<tr>
<td>STEP THREE</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>When all information is received from the Provider or Facility, the appeal will have a full and fair review. Once the review is complete, the provider will be notified in writing of the decision within sixty (60) calendar days.</td>
<td></td>
</tr>
<tr>
<td>STEP FOUR</td>
<td></td>
</tr>
<tr>
<td>If we uphold our original decision, this decision is binding on Provider and BCBSGa. If we overturn our denial, we will indicate that decision in our letter and the additional payment amount will appear on the remittance.</td>
<td></td>
</tr>
</tbody>
</table>

4. Appeal of Urgent and/or Concurrent Decisions.

These are decisions for medical care or treatment that, if the longer time frames for non-urgent care were applied, the delay: (1) could seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that could not be managed without care or treatment that is the subject of the claim.

| STEP ONE |
| This type of appeal may be done verbally. Provider must state they want to file an urgent/concurrent appeal. The Appeal must be accompanied by all supporting documentation for review. |
| STEP TWO |
| The provider may fax the urgent/concurrent appeal containing the words URGENT or CONCURRENT to: 1-855-298-4264. Or they may call the Customer Service number on the back of the member's identification card and ask for an urgent/concurrent appeal. |
| STEP THREE |
| When all information is received from the Provider or Facility, the appeal will have a full and fair review. Once the review is complete, the provider will be notified verbally and in writing of the decision within three (3) days of the request for the appeal. |
| STEP FOUR |
| The decision to either uphold the original denial or to overturn the denial is binding on the physician as no further physician appeals are available. |

PLEASE NOTE: Appeals submitted by a Provider or Facility on behalf of a Covered Individual with the Covered Individual's consent AND when there is Covered Individual liability, or when appealing urgent or concurrent determinations—may be considered a Covered Individual appeal and will be handled accordingly.

Remember to look first to your Provider Agreement as the wording in that Agreement will supersede any discrepancies between the Agreement and the process described above.

Member Quality of Care ("QOC") Investigations

Overview

The Grievances and Appeals department develops, maintains and implements policies and procedures for identifying, reporting and evaluating potential quality of care/service ("QOC"/"QOS") concerns or sentinel events involving BCBSGa Covered Individuals. This includes cases reviewed as the result of a grievance submitted by a Covered Individual and potential quality issues (PQI) reviewed as the result of a referral received from a BCBSGa clinical associate. All BCBSGa associates who may encounter clinical care/service concerns or sentinel events are informed of these policies.

Quality of care grievances and PQIs are processed by clinical associates. Medical records and a response from the Provider and or Facility are requested. If the clinical associate determines the case is a non-issue
with no identifiable quality issue, the clinical associate may assign a severity level C-0. A clinical associate may also assign a severity level rating of C-1 if the case meets the criteria for a known complication. Otherwise, the clinical associate will send a case summary to the Medical Director for review (i.e., First Level Peer Review). The case summary will include a list of previous severity levels assigned to the involved Provider and/or Facility on a rolling 12-month basis. If there are no previous severity levels, this will be documented. The Medical Director will select a specialty matched reviewer to evaluate the case, as appropriate. Upon completion of the review, the Medical Director makes a final determination and assigns a severity level for tracking and trending purposes. Upon completion of First Level Peer Review, if the case is a Covered Individual grievance, the Covered Individual is sent a resolution letter within thirty (30) calendar days of BCBSGa’s receipt of the grievance. The Covered Individual is informed that peer review statutes do not permit disclosure of the details and outcome of the quality investigation. In addition, the clinical associate will send a letter to the Provider and/or Facility explaining the outcome of the review and the severity level assigned.

Significant quality of care issues may be elevated to the regional Peer Review Committee for Second Level Peer Review. This may result in a subsequent referral to the appropriate Credentials Committee.

Trends/patterns of all assigned severity levels are reviewed with the Medical Director for intervention and corrective action planning.

Corrective Action Plans (CAP)

When corrective action is required, the Medical Director or the applicable local Peer Review Committee will determine appropriate follow-up interventions which can include one or more of the following: a CAP from the Provider and/or Facility, CME, chart reviews, on-site audits, tracking and trending, Provider and or Facility counseling, and/or referral to the appropriate committee.

Reporting

G&A leadership reports grievance and PQI rates, categories, and trends to the appropriate Quality Improvement Committee on a bi-annual basis or more often as appropriate. Quality improvement or educational opportunities are reported, and corrective measures implemented, as applicable. Results of corrective actions are reported to the Committee. The Quality Council reviews these trends annually during the process of prioritizing quality improvement activities for the subsequent year.

Severity Levels for Quality Assurance

<table>
<thead>
<tr>
<th>Level</th>
<th>Points Assigned</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-0</td>
<td>0</td>
<td>No quality of care issue found to exist.</td>
</tr>
<tr>
<td>C-1</td>
<td>0</td>
<td>Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern.</td>
</tr>
<tr>
<td>C-2</td>
<td>5</td>
<td>Communication, administrative, or documentation issue that adversely affected the care rendered.</td>
</tr>
<tr>
<td>C-3</td>
<td>5</td>
<td>Failure of a practitioner/provider to respond to a member grievance regarding a clinical issue despite two requests per internal guidelines.</td>
</tr>
<tr>
<td>C-4</td>
<td>10</td>
<td>Mild deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be mildly beneath the standard of care.</td>
</tr>
<tr>
<td>C-5</td>
<td>15</td>
<td>Moderate deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be moderately beneath the standard of care.</td>
</tr>
<tr>
<td>C-6</td>
<td>25</td>
<td>Significant deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be significantly beneath the standard of care.</td>
</tr>
<tr>
<td>Level</td>
<td>Points Assigned</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>S-0</td>
<td>0</td>
<td>No quality of service or administrative issue found to exist.</td>
</tr>
<tr>
<td>S-1</td>
<td>0</td>
<td>Member grievances regarding practitioner’s office: physical accessibility, physical appearance, and adequacy of the waiting-room and examining-room space.</td>
</tr>
<tr>
<td>S-2</td>
<td>5</td>
<td>Communication, administrative, or documentation issue with no adverse medical effect on member.</td>
</tr>
<tr>
<td>S-3</td>
<td>5</td>
<td>Failure of a practitioner/provider to respond to a member grievance despite two requests per internal guidelines.</td>
</tr>
<tr>
<td>S-4</td>
<td>5</td>
<td>Confirmed discrimination, confirmed HIPAA violation, confirmed confidentiality and/or privacy issue.</td>
</tr>
</tbody>
</table>

**Trend Threshold for Analysis**

**Quality of Care and Service Trend Parameters**

The following accumulation of QOC and QOS cases with severity levels and points, or any combination of cases totaling 20 points or more during a rolling 12 months will be subject to trend analysis:

- 8 cases with a leveling of C-0 and S-0
- 4 cases with a leveling of C-1
- 4 cases with a leveling of C-2 and S-2
- 4 cases with a leveling of C-3 and S-3
- 2 cases with a leveling of C-4
- 2 cases with a leveling of C-5
- 1 case with a leveling of C-6 (automatic referral to the applicable Peer Review Committee)
- 3 cases with a leveling of S-1 (for a specific office location in a 6 month period); refer for site visit
- 4 cases with a leveling of S-4 (automatic referral to the applicable Provider Review Committee)

A rolling 12 month cumulative level report is generated monthly and reviewed by a G&A clinical associate for trend identification. (Four similar complaints constitute a trend).

An analysis is completed by the G&A clinical associate and forwarded to the Medical Director to determine if there is a pattern among the cases. For example, a provider who repeatedly fails to return phone calls to postoperative patients resulting in the potential for or an actual adverse outcome. The Medical Director will determine if further action is warranted, such as the need for a corrective action plan, or referral to the appropriate committee for further review and action, as appropriate.

Corrective action plans received for QOC issues are reviewed by the Medical Director and may be forwarded to the applicable local Peer Review Committee for further review and follow up as appropriate.

*A provider who does not submit the corrective action plan by the deadline or who does not comply with the terms of the corrective action plan will be referred to the Credentialing Committee for further action, which may include termination from the network.*

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**Product Summary**

*Product Summary*

*ACA-compliant health plans*
The affordable Care Act (ACA) applies to individuals and small group health plans. These plans can be purchased from the state’s Health Insurance Marketplace, which is commonly referred to as the exchange. Plans can also be purchased off the exchange from traditional sources, such as sales agent.

**BlueChoice PPO**

BlueChoice PPO is the name of BCBSGa’s PPO product. BlueChoice PPO provides in-Network benefits and out-of-Network benefits; the Covered Individual has the option to choose either a preferred Provider or Facility and have benefits paid at the higher in-Network benefit rate, or a non-preferred provider and have benefits paid at the lower out-of-Network benefit rate.

**BlueChoice HMO**

BlueChoice Healthcare Plan is the name of the HMO product. This plan is built on the PCP model, emphasizing the PCP as the coordinator of a Covered Individual’s health care. Physicians in the following specialties are eligible PCPs:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

BlueChoice HMO plan is designed to keep Covered Individuals healthy. When illness occurs, the plan provides for quality care in the most appropriate setting at an affordable cost to employers and Covered Individuals. Covered Individuals have the freedom to select their PCP from a panel of Providers. The PCP provides and arranges all necessary medical services, including preventive care and treatment for illnesses and injuries. The PCP also coordinates referral specialist services and hospitalizations among Providers.

**BlueChoice Option**

BlueChoice Option is the name of the Point of Service (POS) product. A POS plan is a hybrid of an HMO and traditional indemnity coverage. What distinguishes a POS plan from an HMO plan is the inclusion of out-of-Network benefits.

BlueChoice Option Covered Individuals are considered in-Network when they access all healthcare services through their designated PCP and use the services of a Network Provider. If a Covered Individual uses out-of-Network services that are not coordinated by the PCP, his or her benefits are paid at a lower rate, which results in higher out-of-pocket expenses.

**Blue Open Access**

Blue Open Access is the name of the next generation Open Access product. Blue Open Access Covered Individuals are not required to select a PCP and are able to access specialty care through a BlueChoice HMO Specialty Care Physician without a referral from a PCP. Covered Individuals will be encouraged to establish or maintain a relationship with a PCP, since that physician would be most knowledgeable of the Covered Individual’s medical history.

Blue Open Access Covered Individuals will have a specifically branded Covered Individual ID card designating them as an Open Access participant. The card will include copayment amounts along with the standard benefit information included on all Covered Individual ID cards.

**PPO Network Overview**

<table>
<thead>
<tr>
<th>Network</th>
<th>Product Name</th>
<th>Description</th>
<th>PCP Referrals</th>
<th>Out of Network Benefits</th>
<th>Out of State Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>BlueChoice PPO</td>
<td>No PCP Selection Required, No Specialist Referrals Required, INN and OON Benefits, *BlueCard Program for Traveling Covered Individuals</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### HMO Network Overview

<table>
<thead>
<tr>
<th>Network</th>
<th>Product Name</th>
<th>Description</th>
<th>PCP Referrals</th>
<th>Out of Network Benefits</th>
<th>Out of State Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO/POS</td>
<td>Blue Open Access HMO</td>
<td>- HMO Open Access Product</td>
<td>Yes</td>
<td>No</td>
<td>Out of Network benefits are not available, except in Emergencies</td>
</tr>
<tr>
<td></td>
<td>Blue Essential Open Access HMO</td>
<td>- HMO Open Access Hospital/Surgical Product</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blue Open Access POS</td>
<td>- POS Open Access Product</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blue Essential Open Access POS</td>
<td>- POS Open Access Hospital/Surgical Product</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>BCBSGa Lumenos Open Access POS</td>
<td>- POS Open Access Consumer Driven Healthcare Product</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

- PPO Consumer Driven Healthcare Product
- No PCP Selection Required
- No Specialist Referrals Required
- INN and OON Benefits
- *BlueCard Program for Traveling Covered Individuals
- PPO Hospital/Surgical Product
- Limited Benefit Coverage
- No PCP Selection Required
- No Specialist Referrals Required
- INN and OON Benefits
- *BlueCard Program for Traveling Covered Individuals

- Blue Card Program for Traveling Covered Individuals
BlueChoice HMO

- HMO Product
- Requires PCP Selection
- Requires Specialist Referrals
- INN Benefits Only, Except in Emergencies

BlueChoice Option POS

- POS Gatekeeper Product
- Requires PCP Selection
- Requires Specialist Referrals
- INN and OON Benefits

Out of Network benefits are not available, except in Emergencies.

BlueValue Secure Provider Portal

BlueValue Secure Provider Website

Please refer to the Links section of this manual for additional information about BlueValue Secure.

Audit Policy

BCBSGa Audit Policy

This BCBSGa Audit Policy applies to Providers and Facilities. If there is conflict between this Policy and the terms of the applicable Provider or Facility Agreement, the terms of the Agreement will prevail. If there is a conflict in provisions between this Policy and applicable state law that is not addressed in the Provider or Facility Agreement the state law will apply. All capitalized terms used in this Policy shall have the meaning as set forth in the Provider or Facility Agreement between BCBSGa and Provider or Facility.

Coverage is subject to the terms, conditions, and limitations of a Covered Individual’s Health Benefit Plan and in accordance with this Policy.

There may be times when BCBSGa conducts claim reviews or audits either on a prepayment or post payment basis. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the Covered Individual’s plan of treatment or to confirm that charges were accurately reported in compliance with BCBSGa’s policies and procedures as well as general industry standard guidelines and regulations.

In order to conduct such reviews and audits, BCBSGa or its designee may request documentation, most commonly in the form of patient medical records. BCBSGa may accept additional documentation from Provider or Facility that typically might not be included in medical records such as other documents substantiating the treatment or health service or delivery of supplies, Provider’s or Facility’s established internal policies, professional licensure standards that reference standards of care, or business practices justifying the healthcare service or supply. The Provider or Facility must review, approve and document all such internal policies and procedures as required by The Joint Commission (“TJC”) or other applicable accreditation bodies and such policies shall be made available for review by the auditor.

This policy documents BCBSGa’s guidelines for claims requiring additional documentation and the Provider’s or Facility’s compliance for the provision of requested documentation.

Definition:
The following definitions shall apply to this Audit section only:

- **Agreement** means the written contract between BCBSGa and Provider or Facility that describes the duties and obligations of BCBSGa and the Provider or Facility, and which contains the terms and conditions upon which BCBSGa will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Covered Individual(s).

- **Appeal** means BCBSGa’s or its designee’s review of the disputed portions of the Audit Report, conducted at the written request of a Provider or Facility and pursuant to this Policy.

- **Appeal Response** means BCBSGa’s or its designee’s written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.

- **Audit** means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining whether such Health Services have been appropriately reimbursed under the terms of the Agreement.

- **Audit Report and Notice of Overpayment** (“Audit Report”) means a document that constitutes notice to the Provider or Facility that BCBSGa or its designee believes an overpayment has been made by BCBSGa and identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit, that constitute the basis for BCBSGa’s or its designee’s belief that the overpayment exists. Unless otherwise stated in the Agreement between the Provider or Facility and BCBSGa, Audit Reports shall be sent to Provider or Facility in accordance with the Notice section of the Agreement.

- **Business Associate or designee** means a third party designated by BCBSGa to perform an Audit or any related Audit function on behalf of BCBSGa pursuant to a written agreement with BCBSGa.

- **Provider or Facility** means an entity with which BCBSGa has a written Agreement.

- **Provider Manual** means the proprietary BCBSGa document available to the Provider and Facility, which outlines certain BCBSGa Policies.

- **Recoupment** means the recovery of an amount paid to Provider or Facility which BCBSGa has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and BCBSGa. A Recoupment is generally performed against a separate payment BCBSGa makes to the Provider or Facility which is unrelated to the services which were the subject of the overpayment, unless an Agreement expressly states otherwise or is prohibited by law. Recoupments shall be conducted in accordance with applicable laws and regulations.

- **Supporting Documentation** means the written material contained in a Covered Individual’s medical records or other Provider or Facility documentation that supports the Provider’s or Facility’s claim or position that no overpayment has been made by BCBSGa.

**Policy**

Upon request from BCBSGa or its designee, facilities are required to submit additional documentation for claims identified for pre-payment review or post payment audit. Applicable types of claims include, but are not limited to:

1. Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)
2. Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)
3. Claims with unlisted or miscellaneous codes
4. Claims for services requiring clinical review
5. Claims for services found to possibly conflict with covered benefits for Covered Individuals after validity review of the Covered Individual’s medical records
6. Claims for services found to possibly conflict with Medical Necessity of covered benefits for Covered Individuals
7. Claims requesting an extension of benefits
8. Claims being reviewed for potential fraud, abuse or demonstrated patterns of billing/coding inconsistent with peer benchmarks
9. Claims for services that require an invoice
10. Claims for services that require an itemized bill
11. Claims for beneficiaries where other health insurance (OHI) is indicated with the claim submission
12. Claims requiring documentation of the receipt of an informed consent form
13. Claims requiring a certificate of Medical Necessity
14. Appealed claims where supporting documentation may be necessary for determination of payment
15. Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation
16. Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care

BCBSGa or its designee will use the following guidelines for records requests and the adjudication of claims identified for prepayment review or post payment audit:
1. Upon confirmation of Provider’s or Facility’s address, an original letter of request for supporting documentation will be sent.
2. When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.
3. When a response is not received within 15 days of the date of the second request, a final request letter will be sent.
4. When a response is not received within 15 days of the date of the final request (60 days total):
   a. BCBSGa or its designee will initiate claim denial for claims identified as pre-payment review claims as Provider or Facility failed to submit the required documentation. The Covered Individual shall be held harmless for such payment denials.
   or
   b. BCBSGa or its designee will initiate claim retractions for claims identified as post payment audit claims as Provider or Facility failed to submit the required documentation. The Covered Individual shall be held harmless for such payment retractions.

BCBSGa or its designee will not be liable for interest or penalties when payment is denied or recouped when Provider or Facility fails to submit required or requested documentation for claims identified for prepayment or post payment audit.

[This policy will not supersede any individual Provider or Facility contract provisions or state or federal guidelines.]

Procedure:

1. Review of Documents. BCBSGa or its designee will request in writing or verbally, final and complete itemized bills and/or complete medical records for all Claims under review. The Provider or Facility will supply the requested documentation in the format requested by BCBSGa or its designee within the time frame outlined above.
2. Scheduling of Audit. After review of the documents submitted, if BCBSGa or its designee determines an Audit is required, BCBSGa or its designee will call the Provider or Facility to request a mutually satisfactory time for BCBSGa or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.
3. Rescheduling of Audit. Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to BCBSGa or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider’s or Facility’s new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by BCBSGa or its designee due to Provider’s or Facility’s rescheduling.
4. Under-billed and Late-billed Claims. During the scheduling of the Audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by BCBSGa during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit. These Claims may, however, be submitted (or resubmitted for under-billed Claims) to BCBSGa for adjudication.
5. **Scheduling Conflicts.** Should the Provider or Facility fail to work with BCBSGa, or its designee in scheduling or rescheduling the Audit, BCBSGa or its designee retains the right to conduct the Audit with a seventy-two (72) hour advance written notice, which BCBSGa or its designee may invoke at any time. While BCBSGa or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when BCBSGa or its designee must respond quickly to requests by regulators or its clients. In those circumstances, BCBSGa or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.

6. **On-Site and Desk Audits.** BCBSGa or its designee may conduct Audits from its offices or on-site at the Provider’s or Facility’s location. If BCBSGa or its designee conducts an Audit at a Provider’s or Facility’s location, Provider or Facility will make available suitable work space for BCBSGa’s or its designee’s on-site Audit activities. During the Audit, BCBSGa or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Covered Individual authorization. When conducting credit balance reviews, Provider or Facility will give BCBSGa or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, BCBSGa or its designee will have access to Provider’s or Facility’s patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow BCBSGa or its designee access to the items requested to complete the Audit, BCBSGa or its designee may opt to complete the Audit based on the information available. All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.

7. **Completion of Audit.** Upon completion of the Audit, BCBSGa or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit. During the exit interview, BCBSGa or its designee will discuss with Provider or Facility its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation. If the Provider or Facility agrees with the Audit findings, and has no further information to provide to BCBSGa or its designee, then Provider or Facility may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse BCBSGa the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation or Appeal the Audit findings.

8. **Provider or Facility Appeals.** See Audit Appeal Policy.

9. **No Appeal.** If the Provider or Facility does not formally Appeal the findings in the final Audit Report and submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and BCBSGa or its designee will process adjustments to recover the amount identified in the final Audit Report.

**Documents Reviewed During an Audit:**

The following is a description of the documents that may be reviewed by the BCBSGa or its designee along with a short explanation of the importance of each of the documents in the Audit process. It is important to note that Providers and Facilities must comply with applicable state and federal record keeping requirements.

A. **Confirm that Health Services were delivered by the Provider or Facility in compliance with the plan of treatment.**

Auditors will verify that Provider’s or Facility’s plan of treatment reflected the Health Services delivered by the Provider or Facility. The services are generally documented in the Covered Individual’s health or medical records. In situations where such documentation is not found in the Covered Individual’s medical record, the Provider or Facility may present other documents substantiating the treatment or Health Service, such as established institutional policies, professional licensure standards that reference standards of care, or business practices justifying the Health Service or supply. The Provider or Facility must review, approve and document all such policies and procedures as required by The Joint
Commission ("TJC") or other applicable accreditation bodies. Policies shall be made available for review by the auditor.

B. Confirm that charges were accurately reported on the Claim in compliance with BCBSGa’s Policies as well as general industry standard guidelines and regulations.

The auditor will verify that the billing is free of keystroke errors. Auditors may also review the Covered individual's health record documents. The health record records the clinical data on diagnoses, treatments, and outcomes. A health record generally records pertinent information related to care and in some cases, the health record may lack the documented support for each charge on the Covered individual's Claim. Other appropriate documentation for Health Services provided to the Covered individual may exist within the Provider’s or Facility’s ancillary departments in the form of department treatment logs, daily charge records, individual service/order tickets, and other documents. BCBSGa or its designee may have to review a number of documents in addition to the health record to determine if documentation exists to support the Charges on the Covered Individual's Claim. The Provider or Facility should make these records available for review and must ensure that Policies exist to specify appropriate documentation for health records and ancillary department records and/or logs.

Audit Appeal Policy

Purpose:

To establish a timeline for issuing Audits and responding to Provider or Facility Appeals of such Audits.

Procedure:

1. Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the Audit Report. An Appeal of the Audit Report must be in writing and received by BCBSGa or its designee within thirty (30) calendar days of the date of the Audit Report unless State Statute expressly indicates otherwise. The request for Appeal must specifically detail the findings from the Audit Report that Provider or Facility disputes, as well as the basis for the Provider's or Facility’s belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. Retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or State Statute.

2. A Provider’s or Facility's written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by BCBSGa or its designee on a case-by-case basis. If the Provider or Facility chooses to request an Appeal extension, the request should be submitted in writing within thirty (30) calendar days of receipt of the Audit Report. One Appeal extension may be granted during the Appeal process at BCBSGa’s or its designee’s sole discretion, for up to thirty (30) calendar days from the date the Appeal would otherwise have been due. Any extension of the Appeal timeframes contained in this Policy shall be expressly conditioned upon the Provider’s or Facility’s agreement to waive the requirements of any applicable state prompt pay statute and/or provision in an Agreement which limits the timeframe by which a Recoupment must be completed. It is recognized that governmental regulators are not obligated to the waiver.

3. Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, BCBSGa or its designee shall issue an Appeal Response to the Provider or Facility. BCBSGa’s or its designee’s response shall address each matter contained in the Provider’s or Facility’s Appeal. If appropriate, BCBSGa’s or its designee’s Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report. BCBSGa’s or its designee’s response shall be sent via certified mail to the Provider or Facility within thirty (30) calendar days of the date BCBSGa or its designee received the Provider’s or Facility’s Appeal and Supporting Documentation. Revisions to the Audit data will be included in this mailing if applicable.

4. The Provider or Facility shall have fifteen (15) calendar days from the date of BCBSGa’s or its designee's Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to BCBSGa or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, BCBSGa or its designee shall begin recoupment of the amount contained in BCBSGa’s or its designee’s response, and a confirming recoupment notification will be sent to the Provider or Facility.
5. Upon receipt of a timely Provider or Facility response, complete with Supporting Documentation as required under this Policy, BCBSGa or its designee shall formulate a final Appeal Response. BCBSGa's or its designee's final Appeal Response shall address each matter contained in the Provider's or Facility's response. If appropriate, BCBSGa's or its designee's final Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report or final Appeal Response. BCBSGa's or its designee's final Appeal Response shall be sent via certified mail to the Provider or Facility within fifteen (15) calendar days of the date BCBSGa or its designee received the Provider or Facility response and Supporting Documentation. Revisions to the Audit Report will be included in this mailing if applicable.

6. If applicable in the state, the Provider or Facility shall have fifteen (15) calendar days from the date of BCBSGa's or its designee's final Appeal Response to send a remittance check to BCBSGa or its designee. If no remittance check is received within the fifteen (15) calendar day timeframe, BCBSGa or its designee shall recoup the amount contained in BCBSGa's or its designee's final Appeal Response, and a confirming Recoupment notification will be sent to the Provider or Facility.

7. If Provider or Facility still disagrees with BCBSGa's or its designee's position after receipt of the final Appeal Response, Provider or Facility may invoke the dispute resolution mechanisms under the Agreement.

Fraud, Waste and Abuse Detection

BCBSGa recognizes the importance of preventing, detecting, and investigating fraud, waste and abuse and is committed to protecting and preserving the integrity and availability of health care resources for Covered Individuals, clients, and business partners. BCBSGa accordingly maintains a program, led by BCBSGa's Special Investigations Unit (SIU), to combat fraud, waste and abuse in the healthcare industry and against our various commercial plans, and to seek to ensure the integrity of publicly-funded programs, including Medicare and Medicaid plans. All Claims submissions are subject to review and/or audit for possible fraud, waste and abuse. Prevention and detection of fraud, waste and abuse is in accordance with applicable State and Federal law.

Pre-Payment Review Program

One method BCBSGa utilizes to detect fraud, waste and abuse is through pre-payment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to BCBSGa's attention for behavior that might be identified as unusual, or for coding or billing or Claims activity which indicates the Provider or Facility is an outlier with respect to his/her/its peers. For example, BCBSGa uses computer algorithm software tools designed to identify Providers or Facilities whose billing practices, including billing or coding practices, indicate conduct that is unusual or outside the norm of the Provider's or Facility's peers.

Once a Claim, or a Provider or Facility, is identified as an outlier, further investigation is conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual Claim, coding or billing practice. If the investigation results in a determination that the Provider's or Facility's actions may involve fraud, waste or abuse, the Provider or Facility is notified and given an opportunity to respond.

If, despite the Provider's or Facility's response, BCBSGa continues to believe the Provider's or Facility's actions involve fraud, waste or abuse, or some other inappropriate activity, the Provider or Facility will then be notified the Provider or Facility is being placed on pre-payment review. This means that the Provider or Facility will be required to submit medical records with each Claim so BCBSGa can review the services being billed. Failure to submit medical records to BCBSGa in accordance with this requirement will result in a rejection of the Claim under review. The Providers or Facilities will be given the opportunity to request a discussion of his/her/its pre-payment review status.

Under the pre-payment review program, BCBSGa may review coding and other billing issues. In addition, we may use one or more clinical utilization management guidelines in the review of Claims submitted by the Provider or Facility, even if those guidelines are not used for all Providers or Facilities delivering services to Plan's Covered Individuals.
The Provider or Facility will remain subject to the pre-payment review process until BCBSGa is satisfied that any inappropriate activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our Network.

Finally, Providers and Facilities are prohibited from billing Covered Individuals for services we have determined are not payable as a result of the pre-payment review process, whether due to fraud, waste or abuse, any other coding or billing issue or for failure to submit medical records as set forth above. Providers or Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of the applicable Provider or Facility agreement and state law. Providers or Facilities also may appeal such determination in accordance with applicable grievance and appeal procedures.

Federal Employee Health Benefit Program (FEHBP)

FEHBP Requirements

Providers and Facilities acknowledge and understand that BCBSGa participates in the Federal Employees Health Benefits Program ("FEHBP"). The BCBSGa FEHBP encompasses the Blue Cross Blue Shield Association Service Benefit Plan, otherwise known as "Federal Employee Program®" or "FEP®", – the health insurance Plan for federal employees. Providers and Facilities further understand and acknowledge that the FEHBP is a federal government program and the requirements of the program are subject to change at the sole direction and discretion of the United States Office of Personnel Management. Providers and Facilities agree to abide by the rules, regulations, and other requirements of the FEHBP as they exist and as they may be amended or changed from time to time, with or without prior notice. Providers and Facilities further agree that, in the event of a conflict between the Provider or Facility agreement or this Provider Manual and the rules, regulations, or other requirements of the FEHBP, the terms of the rules, regulations, and other requirements of the FEHBP shall control.

When a conflict arises between federal and state laws and regulations, the federal laws and regulations supersede and preempt the state or local law (Public Law 105-266). In those instances, FEHBP is exempt from implementing the requirements of state legislation.

Submission of Claims under the Federal Employees Health Benefits Program

All Claims under the FEHBP must be submitted to Plan for payment within ninety (90) calendar days from the date of discharge or from the date of the primary payer’s explanation of benefits. Providers and Facilities agree to provide to Plan, at no cost to BCBSGa or Covered Individual, all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. If Plan is the secondary payer, the ninety (90) calendar day period will not begin to run until Provider or Facility receives notification of primary payer’s responsibility. Plan is not obligated to pay Claims received after this ninety (90) calendar day period. Except where the Covered Individual did not provide Plan identification, Provider and Facility shall not bill, collect, or attempt to collect from Covered Individual for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.

Erroneous or duplicate Claim payments under the FEHBP

For erroneous or duplicate Claim payments under the FEHBP, either party shall refund or adjust, as applicable, all such duplicate or erroneous Claim payments regardless of the cause. Such refund or adjustment may be made within five (5) years from the end of the calendar year in which the erroneous or duplicate Claim was submitted. In lieu of a refund, Plan may offset future Claim payments.

Coordination of Benefits for FEHBP

In certain circumstances when the FEHBP is the secondary payer and there is no adverse effect on the Covered Individual, the FEHBP pays the local Plan allowable minus the Primary payment. The combined payments, from
both the primary payer and FEHBP as the secondary payer, might not equal the entire amount billed by the Provider or Facility for covered services.

**FEHBP Waiver requirements**

- Notice must identify the proposed services.
- Inform the Covered Individual that services may be deemed not medically necessary or experimental/investigational, by the Plan
- Provide an estimate of the cost for services
- Covered Individual must agree in writing to be financially responsible in advance of receiving the services; otherwise, the Provider or Facility will be responsible for the cost of services denied

**FEHBP Member Reconsiderations and Appeals**

There are specific procedures for reviewing disputed Claims under the Federal Employees Health Benefits Program. The process has two steps, starting with a review by the local Plan (reconsideration), which may lead to a review by the Office of Personnel Management (OPM).

The review procedures are designed to provide Covered Individuals with a way to resolve Claim disputes as an alternative to legal actions.

The review procedures are intended to serve both contract holders and Covered Individuals. The local Plan and OPM do not accept requests for review from Providers or Facilities, except on behalf of, and with the written consent of, the contract holder or Covered Individual.

Providers and Facilities are required to demonstrate that the contract holder or Covered Individual has assigned all rights to the Provider or Facility for that particular Claim or Claims.

When a Claim or request for Health Services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the Covered Individual, contract holder or their authorized representative. The request for review must be received within six months of the date of the Plan’s final decision. If the request for review is on a specific Claim(s), the Covered Individual must be financially liable in order to be eligible for the disputed Claims process.

The local Plan must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses’ notes, related to the Claim. If the additional information is not received within 60 calendar days, the Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. If the Plan does not completely satisfy the Covered Individual’s request, the Plan will advise the Covered Individual of his/her right to appeal to OPM.

Providers or Facilities may not submit appeals to the OPM. Only the Covered Individual or contract holder may do so, as outlined in the Blue Cross and Blue Shield Service Benefit Plan brochure.

**FEHBP Formal Provider and Facility Appeals**

Providers and Facilities are entitled to pursue disputes of their pre-service request (this includes precertification or prior approval) or their post-service claim (represents a request for reimbursement of benefits for medical services that have already been performed), by following a formal dispute resolution process.

A formal Provider or Facility appeal is a written request from the rendering Provider or Facility, to his/her local Plan, to have the local Plan re-evaluate its contractual benefit determination of their post-service Claim; or to reconsider an adverse benefit determination of a pre-service request. The request must be from a Provider or Facility and must be submitted in writing within 180 days of the denial or benefit limitation. In most cases, this will be the date appearing on the Explanation of Benefits/Remittance sent by the Plan. For pre-service request denials, the date will be the date appearing on the Plan’s notification letter.
The request for review may involve the Provider or Facility’s disagreement with the local Plan’s decision about any of the **clinical issues** listed below where the Providers or Facilities are *not* held harmless. Local Plans should note that this list is not all-inclusive.

1. not medically necessary (NMN);
2. experimental/investigational (E/I);
3. denial of benefits, in total or in part, based on clinical rationale (NMN or E/I);
4. precertification of hospital admissions; and,
5. prior approval (for a service requiring prior approval under FEHBP).

Not all benefit decisions made by local Plans are subject to the formal Provider and Facility appeal process. The formal Provider and Facility appeal process does not apply to any non-clinical case.

When a Claim or request for services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the rendering/requesting Provider or Facility. The request for review must be received within six months of the date of the local Plan’s final decision. If the request for review is on a specific Claim(s), the Provider or Facility must be financially liable in order to be eligible for the formal Provider and Facility appeal process.

The local Plans must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses’ notes, related to the Claim. If the additional information is not received within 60 calendar days, the local Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. Even if the local Plan does not completely satisfy the Provider or Facility’s request, the formal Provider and Facility appeal process is complete; no additional appeal rights are available.

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**BlueCard Program Overview**

BlueCard is a national program that enables Covered Individuals of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan’s service area. The program links participating healthcare Providers and Facilities with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for Claims processing and reimbursement. The program allows Providers and Facilities to submit Claims for Covered Individuals from other Blue Plans, domestic and international, to BCBSGa. BCBSGa is the sole contact for Claims payment, adjustments and issue resolution.

For more information about the BlueCard program, Providers and Facilities can access the Blue Card Manual, online at bcbsga.com.

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**Health Insurance Market Place (Exchanges)**

**Health Insurance Marketplace**

The Affordable Care Act (ACA) calls for the development of health plans offered on Health Insurance Marketplaces (commonly referred to as exchanges), as well as health plans not purchased on public exchanges. To support this initiative, BCBSGa developed and/or designated specific networks to serve these ACA compliant health plans and reflect the needs of our membership. Providers and Facilities can easily identify these ACA compliant plans by the network name noted on the Covered Individual ID card.
Critical updates about the products offered on the exchange and the networks supporting these ACA compliant Plans can be found on the Health Insurance Exchange information dedicated web page from our provider home page. Go to bcbsga.com, select Menu, and under the Support heading select the Providers link. In addition to posting information to our website, articles are published in our provider newsletter, Network Update, and sent via our email service, Network ePDATE, to communicate information about exchanges.

Important reminders

Providers and Facilities are able to confirm their participation status by using the Find a Doctor tool. You are able to search by a specific provider name, or view a list of local in-network Providers and Facilities using search features such as provider specialty, zip code, and plan type.

Providers and Facilities who have questions on their participation status are encouraged to contact Provider Services at 1-888-706-3475.

Accessing the Online Provider Directory:
- Go to BCBSGa
- Select the Provider link in the top center of page
- From the Provider Home tab, select the blue box titled “Find a Doctor” to search our online Provider Directory

*If you are referring a Covered Individual to another provider or facility, please verify that the provider is participating in the Covered Individual’s specific network.*

It is critical that your patients receive accurate and current data related to provider availability. Please notify BCBSGa of all changes listed below as soon as possible. **Please note tax ID changes must be accompanied by a W-9 to be valid.**
- Telephone number for Covered Individuals to schedule appointments at your practice location
- Practice/Facility location address
- Practice/Facility Office Hours
- Provider/Facility name
- Practice name
- Practice affiliation changes (i.e. provider joined another group)
- Providers leaving, retiring or joining your practice
- Billing address
- Tax ID number
- Specialties
- Hospital privileges
- Accepting new patients
- Handicapped Accessibility
- Languages offered

Please send us this information timely, preferably within 10 business days, by completing the provider maintenance online form @ bcbsga.com.

Additional information and current communications about Health Insurance Exchanges can be found from the provider homepage at BCBSGa.com

**Medicare Advantage**

**Medicare Advantage Provider Website**

Please refer to the Medicare Eligible website online for additional information at [www.bcbsga.com/medicareprovider](http://www.bcbsga.com/medicareprovider)

Medicare Advantage Provider Manuals are available on the Medicare Eligible website referenced above.
Medicare Crossover Claims

Duplicate Claims Handling for Medicare Crossover

Since January 1, 2006, all Blue Plans have been required to process Medicare crossover Claims for services covered under Medigap and Medicare Supplemental products through Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare Claims to the Blue secondary payer to eliminate the need for Provider or Facilities or his/her/its billing service to submit an additional Claim to the secondary carrier. Additionally, this has also allowed Medicare crossover Claims to be processed in the same manner nationwide.

*Effective October 13, 2013 when a Medicare Claim has crossed over, Providers and Facilities are to wait 30 calendar days from the Medicare remittance date before submitting the Claim to the local Plan if the charges have still not been considered by the Covered Individual's Blue Plan.*

To avoid the submissions of duplicate Claims, use the 276/277 Health care Claims status inquiries to verify Claim and adjudication status prior to re-submission of electronic Claims.

If Provider or Facility provides Covered Individuals’ Blue Plan ID numbers (including alpha prefix) when submitting Claims to the Medicare intermediary, they will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process will take a minimum of 14 days to occur. This means that the Medicare intermediary will be releasing the Claim to the Blue Plan for processing about the same time Provider or Facility receives the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days for Provider or Facility to receive payment or instructions from the Blue Plan.

Providers and Facilities should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit Claims to Medicare to allow for the crossover process to occur and for the Covered Individual’s benefit policy to be applied.

Medicare primary Claims, including those with Medicare exhaust services, that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date, will be rejected by the local Plan.

Effective October 13, 2013, we will reject Medicare primary provider submitted Claims with the following conditions:

- Medicare remittance advice remark codes MA18 or N89 that Medicare crossover has occurred
  - MA18 Alert: The Claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
  - N89 Alert: Payment information for this Claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
- Received by Provider or Facility's local Plan within 30 calendar days of Medicare remittance date.
• Received by Provider or Facility's local Plan with no Medicare remittance date
• Received with GY modifier on some lines but not all
  - A GY modifier is used by Providers and outpatient Facilities when billing to indicate that an item or service is statutorily excluded and is not covered by Medicare. Examples of statutorily excluded services include hearing aids and home infusion therapy.

When these types of Claims are rejected, BCBSGa will also remind the Provider or Facility to allow 30 days for the crossover process to occur or instruct the Provider or Facility to submit the Claim with only GY modifier service lines indicating the Claim only contains statutorily excluded services.

Medicare statutorily excluded services – just file once to your local Plan

There are certain types of services that Medicare never or seldom covers, but a secondary payer such as BCBSGa may cover all or a portion of those services. These are statutorily excluded services. For services that Medicare does not allow, such as home infusion, Providers and outpatient Facilities need only file statutorily excluded services directly to their local Plan using the GY modifier and will no longer have to submit to Medicare for consideration. These services must be billed with only statutorily excluded services on the Claim and will not be accepted with some lines containing the GY modifier and some lines without.

For Claims submitted directly to Medicare with a crossover arrangement where Medicare makes no allowance, Providers and Facilities can expect the Covered Individual’s benefit plan to reject the Claim advising the Provider or Facility to submit to their local Plan when the services rendered are considered eligible for benefit. These Claims should be resubmitted as a fresh Claim to a Provider or Facility’s local Plan with the Explanation of Medicare Benefits (EOMB) to take advantage of Provider or Facility contracts. Since the services are not statutorily excluded as defined by CMS, no GY modifier is required. However, the submission of the Medicare EOMB is required. This will help ensure the Claims process consistent with the Provider’s or Facility’s contractual agreement.

Effective October 13, 2013:

• Providers or outpatient Facilities who render statutorily excluded services should indicate these services by using GY modifier at the service line level of the Claim.
• Providers or Facilities will be required to submit only statutorily excluded service lines on a Claim (cannot combine with other services like Medicare exhaust services or other Medicare covered services)
• The Provider or outpatient Facility’s local Plan will not require Medicare EOMB for statutorily excluded services submitted with a GY Modifier.

If Providers or outpatient Facilities submit combined line Claims (some lines with GY, some without) to their local Plan, the Provider or outpatient Facility’s local Plan will deny the Claims, instructing the Provider or outpatient Facility to split the Claim and resubmit.

Original Medicare – The GY modifier should be used when service is being rendered to a Medicare primary Covered Individual for statutorily excluded service and the Covered Individual has Blue secondary coverage, such as an BCBSGa Medicare Supplement plan. The value in the SBR01 field should not be “P” to denote primary.

Medicare Advantage – Please ensure SBR01 denotes “P” for primary payer within the 837 electronic Claim file. This helps ensure accurate processing on Claims submitted with a GY modifier.

The GY modifier should not be used when submitting:
• Federal Employee Program Claims
• Inpatient institutional Claims. Please use the appropriate condition code to denote statutorily excluded services.

These processes align Blue Cross and/or Blue Shield plans with industry standards and will result in less administrative work, accurate payments and fewer rejected Claims. Because the Claim will process with a consistent application of pricing, our Covered Individuals will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Covered Individual.

Medicare Crossover Claims FAQs

1. How do I handle traditional Medicare-related claims?
   • When Medicare is primary payer, submit claims to your local Medicare intermediary.
   • All Blue claims are set up to automatically cross over (or forward) to the Covered Individual’s Blue Plan after being adjudicated by the Medicare intermediary.

2. How do I submit Medicare primary / Blue Plan secondary claims?
   • For Covered Individuals with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
   • When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the Covered Individual’s ID card for additional verification.
   • Be certain to include the alpha prefix as part of the Covered Individual identification number. The Covered Individual’s ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:
   • If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. DO NOT resubmit that claim to BCBSGa; duplicate claims will result in processing and payment delays.
   • If the remittance advice indicates that the claim was not crossed over, submit the claim to your local BCBSGa Plan with the Medicare remittance advice.
   • In some cases, the Covered Individual identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
   • For claim status inquiries, please contact your local BCBSGa Plan.

3. Who do I contact with claims questions?
   • Your local BCBSGa Plan.

4. How do I handle calls from Covered Individuals and others with claims questions?
   • If Covered Individuals contact you, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number.
- A Covered Individual’s Blue Plan should not contact you directly, unless you filed a paper claim directly with that Blue Plan. If the Covered Individual’s Blue Plan contacts you to send another copy of the Covered Individual’s claim, refer the Blue Plan to your local BCBSGa Plan.

5. Where can I find more information?

For more information:
- Please contact your local BCBSGa Plan.

State Health Benefit Plan

BCBSGa is excited to continue to servicing the Georgia State Health Benefit Plan (SHBP). We are pleased to announce that BCBSGa is Medicare Advantage plan option.

State Health Network = SHBP
The State Health Network = SHBP for HRA Plans and HMO plans (active members/early retirees):
- In Georgia = Open Access POS Network
- Outside of Georgia = BlueCard® National PPO Network (for traveling benefits)

This network is used for all three HRA benefit options and the HMO benefit that SHBP offers to its members.

Communications
BCBSHP added an SHBP specific section to our bi-monthly provider newsletter, Network Update, as well as adding a SHBP specific page to our provider website, bcbsga.com. SHBP information will be posted as it becomes available on the State Health Benefit Plan page. We will also email late breaking important information via Network eUpdate. If you have not yet registered to receive Network eUpdate, please do so by visiting the Communications page of our provider website, bcbsga.com, or contact your Provider Representative for help.

Precertification
SHBP requires precertification for some services that are not required for non-SHBP members. This revised precertification list will be posted to the Precertification page and the SHBP page on our provider website, bcbsga.com. Providers must obtain precertification for the services listed in order to receive reimbursement. Future notifications of changes to the posted precertification list will be done through Network Update and posted to the Precertification page and the SHBP page of our provider website, bcbsga.com.

AIM Specialty Health℠ (AIM) Programs
AIM programs include management of high-tech imaging, echocardiography, specialty pharmacy, radiation therapy and sleep studies and sleep therapy/treatment. All of these services require precertification. In addition, for providers of high-tech imaging services, sleep testing and sleep therapy/treatment, AIM requires the completion of an OptiNetSM online site assessment. The following AIM programs apply to SHBP:
- Diagnostic Imaging Program
- Imaging Cost and Quality Program
- Outpatient Radiation Therapy Program
- Sleep Management Program
- AIM Enhanced Cardiology Program
More information on the AIM programs can be accessed on the Answers@BCBSGa page, the Precertification page on our bcbsga.com provider website, by visiting AIM’s website at aimspecialtyhealth.com, or calling 800-252-2021.

**Specialty Pharmacy**
SHBP has contracted directly with Express Scripts, Inc (ESI) as its pharmacy vendor; however some of the pharmaceuticals may be covered under the member’s medical benefit. Please refer to the SHBP page of our provider website, bcbsga.com, for a list of specialty meds that will determine if they are covered under the Medical or Pharmacy benefit.

**Claim Processing**
Certain benefits, as defined by SHBP, will require specific standard industry codes in order for the service to be considered a covered benefit. Claim submission requirements will be posted to the bcbsga.com provider website.

**SHBP Contact Information**
SHBP has a designated Provider Customer Service department and address. SHBP Provider Customer Service can be reached here.


**Glossary**
Glossary of BCBSGa, Health Care and Managed Care Terms

**65PLUS:**
65PLUS* offers Medicare beneficiaries a choice of five of the federally approved Medicare supplement plans: Plans A, B, C, E and F. Because Medicare only pays a portion of hospital and physician charges, these supplements provide certain benefits otherwise unavailable from Medicare. *65PLUS is underwritten by Blue Cross and Blue Shield of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

**Accreditation:**
Certification that an organization meets the reviewing organization’s standards. Examples: accreditation of HMOs by the National Committee for Quality Assurance (“NCQA”) or accreditation of PPOs by URAC.

**Affiliate(s):**
Any entity owned or controlled, either directly or through a parent or subsidiary entity, by BCBSGa, or any entity which is under common control, with BCBSGa and that accesses the rates, terms or conditions of the Agreement. BCBSGa will have a current listing of such Affiliates available through a commonly available web site or upon request.

**American Accreditation HealthCare Commission, Inc./Utilization Review Accreditation Commission, Inc. (AAHCC/URAC):**
An independent, not-for-profit corporation established in 1990 by organizations representing the managed health care industry, health care providers, consumers, and regulators to encourage more efficient and effective managed care.

**Ancillary:**
A term used to describe additional services performed related to care, such as lab work, x-ray, and anesthesia.

**Appeals:**
Refers to a formal written request (from a practitioner/provider) for reconsideration of a decision previously made by BCBSGa during the complaint process, (e.g., benefit payment, administrative actions, etc.).

**BCBSGa Rate:**
The lesser of Facility’s charges for Covered Services, unless otherwise defined, or the total reimbursement amount that Facility and BCBSGa have agreed upon as specified in the Plan Compensation Schedule (PSC). The BCBSGa Rate shall represent payment in full to Facility for Covered Services.

**Benefit:**
The amount payable by an insurer or employee benefit plan to a claimant, assignee, or beneficiary under the terms of the Health Benefit Plan.

**Benefits Package:**
A term informally used to refer to the employer’s benefit plan or to the benefit plan options from which the employee can choose. “Benefits package” highlights the fact a health benefits plan is a compilation of specific benefits.

**BlueChoice PPO:**
BlueChoice PPO is a preferred provider organization (PPO) that offers Covered Individuals the flexibility of going in or out-of-network for medical care. If Covered Individuals see a physician, specialist or hospital that is in-network (a preferred provider), they receive more savings and benefits. *BlueChoice PPO is underwritten by Blue Cross and Blue Shield of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.*

**Board Certified (Boarded, Diplomat)**
Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

**Case Management:**
A method of coordinating and facilitating services and benefits Covered Individuals receive to ensure they seek and receive appropriate and necessary care to minimize duplication of services, tests and costs and to maximize benefits available under their Covered Individual Agreement.

**Case Rate:**
The all-inclusive BCBSGa Rate for an entire admission or one outpatient encounter. Global Case Rate” means the all-inclusive BCBSGa Rate which includes institutional, professional and physician services for specific Coded Service Identifier(s).

**Certificate Booklet:**
A detailed document that serves both as an explanation of the benefit plan and as the certificate of insurance. See certificate of coverage.

**Certificate of Coverage:**
A description of the benefits included in an insurance plan. The certificate of coverage is required by state insurance laws and represents the coverage provided under the policy issued to the contract holder. The certificate is provided to subscribers via the Certificate Booklet.

**Chargemaster or Charges:**
Facility’s listing of Facility Charges for products, services and supplies.

**Claim:**
Either the uniform bill Claim form or electronic Claim form in the format prescribed by Plan submitted by a Facility for payment by a Plan for Health Services rendered to a Covered Individual. “Complete Claim” means, unless state law otherwise requires, an accurate Claim submitted pursuant to the Agreement, for which all information necessary to process such Claim and make a benefit determination is included.

**Coded Service Identifier(s):**
A listing of descriptive terms and identifying codes, updated from time to time by the Centers for Medicare and Medicaid Services (CMS) or other industry source, for reporting Health Services on the UB-04 or its successor. The codes include but are not limited to, CPT-4, HCPCS, ICD-9 or successor codes, National Drug Code (NDC) and Revenue Codes, or their successors.

**Concurrent Review:**
A component of Utilization Management program which evaluates a Covered Individual’s coverage for Facility services under the terms of the contract.
**Contract:**
A binding written agreement between the insurer and policyholder to evidence the terms and conditions of the policy. The contract between Blue Cross and Blue Shield of Georgia and an insured includes the certificate booklet.

**Coordination of Benefits (COB):**
A provision in a contract that applies when a person is covered under more than one group medical program. It requires that payment of benefits will be coordinated by all programs to eliminate over-payment by insurance or duplication of benefits.

**Cost Share:**
With respect to Covered Services, an amount which a Covered Individual is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Covered Individual payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Covered Individual.

**Covered Individual:**
Any individual who is eligible, as determined by Plan, to receive Covered Services under a Health Benefit Plan. For all purposes related to the Agreement, including all schedules, attachments, exhibits, manual(s), notices and communications related to the Agreement, the term “Covered Individual” may be used interchangeably with the terms Insured, Covered Person, Member, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child or Contract Holder, and the meaning of each is synonymous with any such other.

**Covered Individual ID Card:**
An identification card issued by PLAN or an Affiliate, which identifies an individual as a Covered Person. (The Covered Individual Card is for identification purposes only and may not be used as verification of eligibility.)

**Covered Services:**
Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Covered Individual is eligible.

**Credentialing:**
The process of reviewing a provider’s credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for inclusion in a Network are met. BCBSGa screens all physicians in their Networks. Each physician must meet specific educational and medical practice standards in order to become part of the Network.

**Deductible:**
The amount of covered expenses that must be incurred and paid by each Covered Individual before benefits become payable by the insurer. For example, if a plan has a $100 deductible, the deductible is met once the first $100 of the covered medical expenses for that year has been paid. After that, the plan begins to pay toward the cost of covered health care services.

**Dependent:**
A covered person’s spouse (not legally separated from the insured) and unmarried child(ren) who meet eligibility requirements.

**Discharge Planning:**
Component of Utilization Management program which evaluates a Covered Individual’s coverage under the terms of the Covered Individual’s contract for health care services after discharge from an inpatient setting.

**DRG:**
Diagnosis Related Group as set forth by the CMS or other grouper as may be used by BCBSGa and updated as codes are updated.

**Drug Formulary:**
A listing of prescription medications which are approved for coverage by the plan. The list is subject to periodic review and modification by the health plan.
**Eligibility:**
The provisions of the group policy or insurance contract that state the requirements that applicants must satisfy to become insured with respect to themselves or their dependents.

**Emergency Condition:**
A condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in: (1) placing the Covered Individual’s health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction to any bodily organ or part; or (4) other serious medical consequences.

**Employer Group**
A group of eligible employees to whom health care benefits are extended through a health benefits plan provider. The relationship is formalized through a contract. For the employer group to be recognized, a true employee-employer relationship must exist. Examples of groups which would not qualify include social clubs and independent contractors.

**Exclusions:**
Specific conditions or circumstances listed in the Health Benefit Plan for which the policy or plan will not provide benefit payments.

**Facility Based Physician:**
Any physician, with the exception of residents, interns and fellows, who has a contractual relationship with a Facility to provide professional services. These services may be of two types: (1) administrative, managerial, teaching, or quality control activities compensated from or through a Facility which are furnished to a Facility or its general population; or (2) physician services personally rendered to a Covered Individual while in a Facility which directly contribute to the diagnosis or treatment of a Covered Individual and which ordinarily require performance by a physician, including, an emergency room physician, radiologist, pathologist, and anesthesiologist, and any other physicians contracting with hospitals specified by BCBSGa, at any time, or from time to time; provided, however, that this term shall not include PCPs or Specialty Care Physicians employed by a Facility who have a separate contractual agreement with BCBSGa.

**Fee-for-Service Reimbursement:**
A method of reimbursement by which a Provider charges, and is reimbursed, separately for each patient encounter or service rendered.

**Fee Schedule Rate:**
The BCBSGa Rate payable to Facility based on a specific Coded Service Identifier(s), as set forth in the applicable fee schedule(s).

**FEHBP:**
The “Federal Employee Health Benefit Program” is a group contract to provide health care benefits to federal employees, underwritten by Blue Cross and Blue Shield Plans. The official name of the program is the Government-Wide Service Benefit Plan.

**Group Health Coverage:**
A health benefits plan which covers a group of people as permitted by state and federal law.

**Guest Covered Individual:**
Covered Individuals of an Affiliate of BCBSGa temporarily residing in a Service Area. Guest Covered Individual(s) will be treated as BCBSGa Covered Individuals while present in a Service Area.

**Health Benefit Plan:**
The document(s) describing the partially or wholly: (1) insured, (2) underwritten, and/or (3) administered, marketed health care benefits, or services program between the Plan and an employer, governmental entity, or other entity or individual.

**Health Service:** Those services or supplies that a health care Facility is licensed equipped and staffed to provide and which it customarily provides to or arranges for individuals.

**HEDIS (Health Plan and Employer Data Information Set):**
HEDIS is a standard set of more than 100 indicators developed to assist purchasers/employers in evaluating
health plans. HEDIS has become a standard of measurement for the Centers for Medicare and Medicaid Services (CMS), for some state insurance departments and for many large companies. HEDIS has also become a component of the NCQA accreditation process.

**Home Health Agency:**
A Facility or program licensed, certified or otherwise authorized pursuant to state and federal laws to provide home health care services.

**Hospice:**
A Facility or program licensed or certified under law to provide palliative and supportive care for the terminally ill.

**Indemnity:**
Indemnity or “traditional” insurance is a plan which reimburses physicians for covered charges for services performed, or insures for medical expenses incurred.

**In-Network:**
In-network means seeing a provider that has contracted with BCBSGa to participate in the network of physicians and hospitals.

**Inpatient Services:**
Covered Services provided by Facility to a Covered Individual who is admitted and treated as a registered inpatient, is assigned a licensed bed within the Facility, remains assigned to such bed and for whom a room and board charge is made.

**Length of Stay (LOS):**
The number of days that a Covered Individual stayed in an inpatient Facility.

**Managed Care:**
A health plan or insurance program in which beneficiaries receive medical service in a coordinated manner to eliminate unnecessary medical services. In managed care health plans, the Covered Individual seeks specialist or hospital care after prior approval of coverage by designated health care professionals, such as PCPs, utilization review nurses, or employer-designated professionals. The primary goal is to deliver cost-effective health care without sacrificing quality or access.

**Medically Necessary or Medical Necessity:**
Covered Services or supplies provided by a Facility, physician, or other provider to identify or treat an illness or injury and which, as determined by Plan, are: 1) appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient’s condition; 2) compatible with the standards of acceptable medical practice in the United States; 3) not provided solely for the Covered Individual’s convenience or the convenience of the physician, health care provider or Facility; 4) not primarily custodial care; and 5) provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.

**Medicare:**
Title XVIII of the Social Security Act which provides payment for medical and health services to the population aged 65 and over regardless of income, as well as certain disabled persons and persons with ESRD.

**Covered Individual ID Card:**
A card given to each Covered Individual by BCBSGa which introduces the Covered Individual to physicians and hospitals. Although the cards do not guarantee eligibility for medical care benefits at any given time, they increase the convenience of obtaining health insurance services.

**NCQA:**
The National Committee for Quality Assurance is an independent, not-for-profit entity that works closely with the managed care industry, health care purchasers, researchers and consumers to develop standards for accreditation to determine whether a managed care organization is founded and practicing principles of quality and is continuously working to improve the services it provides. Typically NCQA auditors use these standards to evaluate managed care organizations with regards to quality management and improvement, utilization management, credentialing, Covered Individual rights and responsibilities, preventive health services, and medical records.
Network:
A group of providers that support, through a direct or indirect contractual relationship, some or all of the product(s) and/or program(s) in which Covered Individuals are enrolled.

Non-Participating Provider(s):
A non-participating provider is a physician, Facility or other medical provider that has not entered into an agreement with BCBSGa to provide health care services to Covered Individuals.

Observation:
The services furnished by a Provider on the Facility’s premises, regardless of the length of stay, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary after surgery or to evaluate an outpatient condition and determine the need for a possible admission to the Facility as an inpatient.

Open Enrollment:
A period when eligible persons can enroll in a health benefits plan.

Other Payors:
Persons or entities, utilizing the Networks/Plan Programs pursuant to an agreement with BCBSGa or an Affiliate, including without limitation, other Blue Cross and/or Blue Shield Plans that are not Affiliates, self-administered or self-insured programs providing Health Benefit Plans, or employers or insurers.

Outpatient Services:
Covered Services other than Inpatient Services which are provided to a Covered Individual by Facility.

Out-of-Pocket:
Those medical expenses which an insured is required to pay because they are not covered under the group contract.

Participation Attachment:
The document(s) attached to, or made a part of the Agreement which identifies the additional duties and obligations related to Network(s) and/or Plan Programs.

Patient Day:
Each approved calendar day of care that a Covered Individual receives in the Facility, to the extent such day of care is a Covered Service under the terms of the Covered Individual’s Health Benefit Plan, but excluding the day of discharge.

Per Diem Rate:
The BCBSGa Rate that is expressed as an all-inclusive fixed payment for each Patient Day of admission or one outpatient encounter.

A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health care industry’s standard for reporting physician procedures and services, thereby providing an effective method of nationwide communication.

Plan:
Refers to (1) BCBSGa; (2) an Affiliate as designated by BCBSGa; and/or (3) Other Payor.

Plan Compensation Schedule (PCS):
The document(s) attached to, or made a part of the Agreement which set forth the BCBSGa Rate(s) for the Network(s) in which Facility participates.

Plan Program:
Any program now or hereafter established, marketed, administered, sold, or sponsored by Plan, or Blue Cross Blue Shield Association (“BCBSA”) (and includes the Health Benefit Plans that access, or are issued, or entered into in connection with such program). Plan Program shall include but is not limited to, a health maintenance organization, a preferred provider organization, a point of service product or program,
exclusive provider organization, an indemnity product and program, and a quality program(s). The term Plan Program shall not include any program excluded by Plan or BCBSA.

**Point-of-Service:**
A managed care product that offers the advantages of an HMO with the flexibility of a traditional health insurance plan. Covered Individuals decide where to receive care when they need it at the point-of-service.

**Pre-admission Review:**
A component of a Utilization Management program which reviews an inpatient Facility stay prospectively to determine coverage.

**Preauthorization:**
A prospective process to verify coverage of proposed care, to establish covered length of stay and to set a date for concurrent review.

**Preferred Provider Organization (PPO):**
A Network of facilities and physicians who agree to participate in a PPO Network. Covered Individuals of this type of product may incur higher out-of-pocket expenses for covered services received outside the PPO.

**Protected Health Information (PHI):**
Individually identifiable health information transmitted or maintained in any form or medium (including orally, electronically or on paper).

**Primary Care Physician (“PCP”):**
A primary care physician is a physician who is a family or general practitioner, internist or pediatrician. PCPs provide a broad range of routine medical services and refer Covered Individuals to specialists, facilities and other providers as necessary. Each covered family Covered Individual who participates in BlueChoice HMO or Blue Choice Option, chooses his or her own PCP from the Network’s physicians.

**Specialists:**
Providers whose practices are limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose and throat), or specific procedures (e.g., oral surgery).

**URAC:**
An independent, not-for-profit corporation established in 1990 by organizations representing the managed health care industry, health care providers, consumers, and regulators to promote continuous improvement in the quality and efficiency of health care management through processes of accreditation and education.

**Utilization Management:**
The process of evaluating a proposed hospitalization, service, or procedure and determining whether the hospitalization, service or procedure meets established guidelines and criteria to be covered under a Covered Individual’s contract.

**Wellness Programs:**
A broad range of employer sponsored facilities and activities designed to promote safety and good health among employees. Its purpose is to reduce the costs of accidents, sickness, absenteeism, lower productivity and health care costs.

Exhibits
Notice of Potential Liability Form

NOTICE OF POTENTIAL LIABILITY
BLUE CROSS and BLUE SHIELD OF GEORGIA, INC.

Patient Name ____________________________________________________________

Address __________________________________________________________________

ID/Contract # __________________________________________________________________

Group # ___________________________ Date of Service ______/_____/_______

Based on the information available at this time, ________________ (Provider or Facility) and Blue Cross and Blue Shield of Georgia, Inc. (BCBSGa) have determined that the following will not be reimbursed by BCBSGa under the member’s Membership Agreement.

__________ Inpatient Admission for _____/_____/______

__________ Additional Inpatient Treatment after _____/_____/______

__________ Other Hospital or Outpatient services _____/_____/______

Estimated cost of services: __________________________________________________________________

Expenses incurred for the above treatment(s) will be the responsibility of the member/patient.

Should the member or attending physician disagree with this decision, the member or the attending physician should refer the matter to the Utilization Management Division of BCBSGa.

ACKNOWLEDGEMENTS:

Member Signature ___________________________ Hospital Representative Signature ___________________________

Member Printed Name ___________________________ Hospital Representative Printed Name ___________________________

Date ___________________________ Hospital Representative Title ___________________________

Date ___________________________
FEE SCHEDULE REQUEST FORM

For all participating physicians and hospital based providers statewide.

Please send request via email or fax to:

Email: To your Provider Rep or Fax: 877-551-6184

Chiropractors please contact American Specialty Health Network (ASHN) at 800-972-4226 for Fee Schedule Requests.

Ancillary Providers, please contact Ancillary for Fee Schedule Requests at 404-479-8615.

Please complete the following required information to provide fee schedule:

Provider or Group Name: __________________________________________
Provider or Group Address __________________________________________
Tax ID: __________________________________________________________
NPI #: ___________________________________________________________
Provider Specialty: _________________________________________________
Contact Name: ____________________________________________________
Contact Phone #: _________________________________________________
Email Address: ____________________________________________________

➢ Please select the network(s) fee schedule needed:  [ ] HMO  [ ] PPO
  [ ] PAR  [ ] Open Access  [ ] Pathway

Please note that the inclusion of a specific procedure code on the attached report should not be viewed as an assurance or guarantee of coverage or payment. BCBSGA members’ benefit plans vary widely and are subject to change based on the contractual effective dates. Claim payment and procedure coverage determinations are made in accordance with an individual member’s benefits in effect on the date that services are rendered.

BCBSGA will respond to your Fee Schedule Request within five (5) business days by email.
APPENDIX A - QUALITY CARE PROVIDERS, INC. (ATLANTA AREA ONLY)

Quality Care Providers, Inc. ("QCPI"), a Georgia non-profit corporation, is an independent practice network consisting of over one-thousand, four-hundred and fifty (1450) PCPs, practicing in Internal Medicine, Family Practice and Pediatrics in and around metropolitan Atlanta. QCPI was formed in 1993. Its mission is to meet the recognized objectives of managed care: high quality care, access and cost efficiency. QCPI seeks to integrate its physicians both clinically and economically through a number of activities including, but not limited to:

1. Providing a means of integrating financial and provider management in connection with the delivery of health care services, emphasizing the role served by PCPs as coordinators and managers of patient care in managed health care plans;

2. Providing a means for contracting for health care services with PCPs on a quality-sensitive, discounted, capitated and/or other cost-effective basis;

3. Promoting efficiency and cost-effectiveness in the providing of health care services by techniques such as electronic data interchange among Network/Participating Providers and payors, and offering financial incentives to PCPs to encourage use of these techniques;

4. Providing a means to encourage and be responsible for PCPs’ use of utilization and quality management activities; and

5. Improving access for residents of the Atlanta community to quality, affordable health care.

QCPI currently has an agreement with BCBSGa. to deliver primary care services to purchasers of certain managed care health insurance products.

QCPI CONTACT INFORMATION

Address: Quality Care Providers, Inc.
3350 Peachtree Road NE
Suite 1180
Atlanta, GA 30326

Phone: (678) 553-4600
Fax: (678) 553-4601
Email: contact@qcpi.org

QCPI Officers:

Kenneth E. Jones, MD Chairman
Michael J. Kinstler, MD President, Chief Medical Officer
Joel A. Goldstein, MD Executive Vice President, Treasurer
S. Catherine Huggins, MD Executive Vice President, Secretary
Joseph M. Rosenfeld, MD Assistant Secretary

QCPI Board of Directors:

Family Practitioners
Kenneth E. Jones, MD
Miles E. Brett, MD
S. Catherine Huggins, MD

Pediatricians
Joseph M. Rosenfeld, MD
Joel A. Goldstein, MD
J. Vincent Vigil, MD

Internists
Michael Kinstler, MD
Jitendra Singh, MD
Imani D. Vannoy, MD
NOTIFICATION REQUIREMENTS

Each PCP acknowledges that in order to remain a QCPI provider he/she must, on an ongoing basis, meet QCPI credentialing standards. To view a copy of the standards, visit www.qcpi.org.

In addition, each PCP must notify QCPI within three (3) business days of the occurrence of any of the following:

1. The filing of a professional malpractice lawsuit against the PCP or the final disposition of any professional malpractice lawsuit against the PCP or any judgment or settlement involving the PCP which might materially impair the PCP’s ability to provide health care services to Covered Individuals; or

2. Any revocation, reduction, restriction, suspension, limitation, termination, denial or voluntary relinquishing of any professional license, permit, certification, medical staff membership or privilege or participation in the Medicare or any Medicaid program occurring on or after the date of the PCP’s Independent Physician Agreement, or any notification from any governmental body indicating the potential change in the PCP’s receiving any change or notification of potential change in the PCP’s professional licensure or DEA certificate status; or

3. Any resignation from the medical staff of any hospital or clinic, whether or not such hospital or clinic is a Network /Participating Provider (and such notice must include the reason(s) therefore); or any denial, modification, revocation, curtailment or limitation, in any manner, for any reason, including without limitation, reasons involving patient medical care, of medical staff privileges of the PCP at any hospital or clinic (whether or not such hospital or clinic is a Participating Provider), excluding temporary suspensions for failure to comply with such institution's medical record regulations; or the taking of any action affecting the medical staff privileges of PCP at any hospital or clinic that may reasonably be expected to impair the ability of the PCP to perform under the PCP’s Independent Physician Agreement or as required in this Network Manual; or

4. Any indictment, arrest or conviction for any felony or for any criminal charge related to, incidental to or in any manner involving the PCP or the PCP’s services; or

5. Any determination of bankruptcy, whether initiated voluntarily or involuntarily, of the PCP or any professional corporation or other entity of which the PCP is an owner, partner or employee, or any order appointing a receiver with respect to same; or

6. Any dishonest or unethical behavior by PCP which may result in damage to or discredit upon QCPI.

7. Any denial of or termination of any professional liability insurance; or

8. The PCP’s ceasing to practice in Internal Medicine, Family Practice or Pediatrics with an office which is open a minimum of 4 days per week and with the PCP’s providing at least 20 hours per week of physician-patient contact.

Each PCP is to send a notice to BCBSGa within three (3) business days of the PCP receiving any change or notification of potential change in his/her professional licensure or DEA certificate status and is to notify BCBSGa within fifteen (15) days of receipt of actual notice of the occurrence of any of the following:

1. Any change to the information submitted on the initial or recredentialing Physician Application.
2. Any change in ownership or business address.
3. Any legal or governmental action or any other problem or situation which might impair the ability of the PCP to carry out his/her duties and obligations under his agreement with QCPI, including, but not limited to, employee strikes or walkouts, financial insolvency or damages to the physical plant resulting in any interruption of the provision of medical services.
4. Any suit or claim by a Covered Individual against the PCP.
5. Any disciplinary action taken by QCPI that result in termination.
Notices required under this Section are to be sent to:

Quality Care Providers, Inc.
3350 Peachtree Road NE
Suite 1180
Atlanta, Georgia 30326
Fax: (678) 553-4601
Email: contact@qcpi.org

AND TO:

Blue Cross Blue Shield of Georgia
Provider Services
Mail Code GAG006-0010
3350 Peachtree Road NE
Atlanta, GA 30326
Fax: Provider Services at (404) 842-8488 or (404) 842-8149

STATUS CHANGES:

ADDING NEW PHYSICIAN(S) TO PRACTICE/GROUP

PCPs must notify BCBSGa and QCPI, in writing, of the addition of physician(s) to their practice group. A copy of the new physician’s CV is to be submitted with the notice.

The new physician must be approved for participation by QCPI and must meet all credentialing criteria required by QCPI (and by BCBSGa). In order to be reviewed by the QCPI Credentialing Committee for inclusion in the network, the appropriate credentialing application must be submitted. To view a copy of the standards, visit www.qcpi.org. The QCPI Credentialing Committee meets once a month.

The Board of Directors of QCPI, either directly or through its Executive Committee, in its sole discretion, has the right to accept or reject applications for participation on the PCP’s panel.

Please send notice of addition of physician(s) to the practice group and their CVs to the following addresses:

Quality Care Providers, Inc.
3350 Peachtree Rd. NE
Suite 1180
Atlanta, GA 30326
Fax: (678) 553-4601
Email: contact@qcpi.org

AND TO:

Blue Cross Blue Shield of Georgia
Provider Services, Mail Code GAG006-0010
3350 Peachtree Road NE
Atlanta, GA 30326
Fax: (404) 842-8149

DEPARTURE OF A PHYSICIAN FROM A PRACTICE/GROUP

PCPs must notify QCPI and BCBSGa, in writing, if he or she leaves his/her current practice or group.

In addition, each practice which has Provider s should also notify QCPI and BCBSGa if a Provider leaves the practice or group.
Sixty (60) days’ notice is recommended in cases of deletion of a physician(s) from a practice or group in order to allow timely updates.

Please send notice to the following addresses:

Quality Care Providers, Inc.
3350 Peachtree Road NE
Suite 1180
Atlanta, Georgia 30326
Fax: (678) 553-4601
Email: contact@qcpi.org

AND TO:

Blue Cross Blue Shield of Georgia
Provider Services
Mail Code GAG009-0003
3350 Peachtree Road NE
Atlanta, GA 30326
Fax: (404) 842-8149

TERMINATION BY PHYSICIAN

A PCP desiring to withdraw from the QCPI network must notify QCPI in writing ninety (90) days in advance of the anticipated termination of his/her Independent Physician Agreement. The 90-day period for notice of cancellation will begin upon the earlier of: when personally delivered, when received or three (3) days after the date mailed. See Article XI, Sections 11.6 and 12.11 of the QCPI Independent Physician Agreement.

Please send notice to the following address:

Quality Care Providers, Inc.
3350 Peachtree Road NE
Suite 1180
Atlanta, GA 30326
Fax: (678) 553-4601

WITH A COPY TO:

Blue Cross Blue Shield of Georgia
Provider Services
Mail Code GAG006-0010
3350 Peachtree Road NE
Atlanta, Georgia 30326
Fax: (404) 842-8149

TERMINATION BY QCPI

QCPI may terminate a PCP’s Independent Physician Agreement with or without cause by giving sixty (60) days prior notice to the PCP, as provided for in Section 11.3 of the QCPI Independent Physician Agreement.
APPENDIX B

Georgia Rural Healthcare Initiative
(Telemedicine)

BCBSGa in cooperation with Georgia Insurance and Fire Commissioner, Ralph Hudgens, have launched the Commissioner’s advanced telemedicine network for the delivery of health care services to patients in traditionally underserved rural areas. Telemedicine is a health care delivery method that applies high-speed telecommunication systems, computer technology and specialized medical cameras to examine, diagnose, treat and educate patients from a distance.

For example, through a telemedicine encounter, a patient in Alma, Georgia may seek medical treatment from one of Georgia’s leading specialty hospitals without spending the time and money required to travel for an in-person appointment.

The driving force behind the development of the telemedicine network was to enable patients in rural areas throughout the state to have access to the type of specialty care previously available only in the larger population centers. The program promises to:

- Increase access to specialty care throughout Georgia
- Improve timeliness of diagnosis and treatment
- Improve the quality of care for rural patients

The Georgia telemedicine program utilizes more than 45 specialties including cardiology, dermatology, endocrinology, neurology, pediatrics, psychiatry and rheumatology. The telemedicine network consists of 42 presentation sites located in rural hospitals or hospital-associated clinics connected to academic medical center or related care facilities. The goal is to enable patients anywhere in Georgia to have access to specialty care within a 30-minute drive or less. Current plans call for referral or specialty care sites to be established at:

- Emory University Hospital in Atlanta
- Medical College of Georgia in Augusta
- Piedmont Hospital in Atlanta
- Memorial Health in Savannah
- Archbold Medical Center in Thomasville

While the application of telemedicine varies based on the specialty consult needed, the sites will be equipped to offer two methods as outlined below:

- **Live Video** - Via live video, the primary care provider, the patient and a specialist meet at the same time using telemedicine video and telephone equipment. As the patient’s physician, you decide whether a specialist is needed and if it may be best to use the telemedicine equipment. The patient then agrees to have the appointment via telemedicine rather than in person. The telemedicine presentation site schedules the telemedicine appointment and provides all of the information to the specialist. During the appointment, the patient is “presented” by someone at the presentation site to the specialist using a telemedicine video camera. The specialist then makes the recommendations to help the patient.

- **Store and Forward** – For a Store and Forward telemedicine visit; an image of the patient’s condition is taken and sent electronically to the specialist for review. The patient’s physician must first decide whether a specialist should review the patient’s condition. Once the patient agrees to have an electronic image taken of their condition, the presentation site then forwards the patient’s information and images to the specialist. Based on the images, the specialist makes recommendations to help the patient and returns the recommendations to the presentation site.
Most telemedicine visits take from 15 to 20 minutes. It’s easier and faster for patients to “see” a specialist without driving long distances. As the patient’s physician, you can choose from a variety of specialists to “see” your patients, no matter where they live. Additionally, you can send patient medical information and pictures of the patient’s condition to a specialist for a second opinion. Most importantly, you stay involved with the care your patients receive. Claims must be submitted with either the GQ or GT modifiers.

The telemedicine network will provide an open web of access points established throughout the state, connecting rural areas, where barriers to specialty care typically exist. This open access network will offer unprecedented access to specialty care.

Links

Contact Us
http://www.bcbsga.com/wps/portal/chpproviderbcbsga?content_path=provider/noapplication/providerservices/contactus/notertiary/pw_ad031465.htm&rootLevel=3&label=Contact%20Us

Medical Policy and Clinical UM Guidelines Link

Centers of Medical Excellence
http://www.bcbsga.com/wps/portal/chpproviderbcbsga?content_path=shared/noapplication/healthinformation/preventivecare/tobacco/cessation/pw_b130390.htm&rootLevel=1&label=Centers%20of%20Medical%20Excellence

Federal Employee Health Benefit Program (FEHBP) Website
http://www.fepblue.org/

BlueValue Secure Provider Website

Quality
http://www.bcbsga.com/wps/portal/chpproviderbcbsga?content_path=provider/noapplication/f0/s0/t0/pw_b126978.htm&rootLevel=1&label=Quality%20Improvement%20and%20Standards

EDI

Provider Home-Local-GA
http://www.bcbsga.com/home-providers.html