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Claims, Compliance Program, IT System Security, and Oversight Monitoring

A Supplement to the HMO IPA/Medical Group Procedures Manual

April 2024

Claims, Compliance Program, IT System Security, and Oversight Monitoring

This supplement has been written as a guide for a Delegated Entity. A Delegated Entity refers to IPA/medical groups, hospitals, specialty plans/vendors, medical service organizations, third party administrators (TPAs) or others who process claims delegated by Blue Shield of California (Blue Shield). Blue Shield hopes the information and procedures in this supplement will assist in meeting delegated requirements for Claims, Compliance Program, IT System Security, and other Regulatory Oversight Monitoring. For any questions or further assistance, please contact your assigned Delegated Oversight Auditor(s). This supplement includes the following sections:

- **Claims Introduction**
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Claims, Compliance Program, IT System Security, and Oversight Monitoring

Claims Introduction

This supplement to the Blue Shield *HMO IPA/Medical Group Procedures Manual* is for the Delegated Entity that 1) processes its own claims, 2) contracts with a management company or Third-Party Administrator (TPA) to process claims on its behalf, or 3) sub-capitates (sub-delegates) some or all of its claims processing responsibilities. If the Delegated Entity is currently not processing their claims, the IPA/medical group must share this supplement with their TPA or management company or otherwise ensure that they have the latest version of this specific update. If the Delegated Entity sub-capitates claims processing, or ever contemplates doing so, please carefully read the "Sub-Capitated (Sub-Delegated) Claims Monitoring" section of this appendix below. It explains the additional responsibilities you assume when you sub-capitate the claims processing function.

By means of this supplement, Blue Shield seeks to describe and follow sound operating principles. This supplement will guide you in providing superior service to our beneficiaries and in applying industry best practices in your claims operations. It will help you to verify that you are successful in meeting all applicable requirements. Please do not hesitate to contact your assigned Blue Shield Delegated Claims Oversight Auditors directly for further information or assistance.

Based on the available data, the information in this supplement conforms to all CMS, DMHC and DOL requirements. Should information in this supplement fail to reflect any existing or newly enacted statutory requirements, these new or additional requirements will supersede the information contained herein. Blue Shield will notify the Delegated Entity of any changes in requirements through supplemental revisions or by other written communications. Throughout this document, wherever possible, Blue Shield distinguishes between Medicare Advantage (HMO) requirements and DMHC ("commercial") requirements or citations by displaying them side-by-side.

This supplement only describes claims, compliance program, IT system security and oversight monitoring. Information on other claims-related topics (i.e., claims operations coordination with Blue Shield; submission of encounter claims or data; claims appeals or grievances; Medicare Secondary Payment (MSP); and coordination of benefits (COB)) are covered in other parts of the *HMO IPA/Medical Group Procedures Manual.*

Key Terms and Definitions

Affiliated/Contracted Provider

A provider with whom the plan and/or a Delegated Entity has a signed contractual agreement in place on the date of service. A contractual agreement can be an actual written contract, a one-time letter of agreement (LOA), a memorandum of understanding (MOU), or a provider rendering services while on-call or covering for a contracted provider.

Claims Operations

Blue Shield monitors compliance and deficiencies across all aspects of Delegated Entity's claims operations: receipt and related handling, processing/adjudication, and payment. The claim operation begins when the claim is first received from the US Postal Service, electronically or by any other means and ends when the check or disbursement, explanation of benefits (EOB) or notice of denial is electronically transmitted or deposited in the US mail. These operations are defined to include computer systems and their reports, as well as utilization review, and any other ancillary operations in the workflow needed to fully process a claim and deliver the payment and/or denial.

Clean Claim

A clean claim is defined as "one which can be paid and/or denied as soon as it is received, because it is complete in all aspects, including complete coding, itemization, dates of service, billed amounts, and identification of the billing provider including tax identification number (TIN)" and the national provider identifier (NPI).

Emergency services or out-of-area urgently needed services do not need authorization to be considered "clean," providing that the presenting ICD-10-CM diagnoses codes or accompanying medical records substantiate that they qualify as emergent, urgent under the reasonable person standard.

Complete Claim

A complete claim is one that includes all necessary information to determine payor liability. Information necessary to determine payor liability for the claim includes, but is not limited to, reports or investigations concerning fraud and misrepresentation, necessary consents, releases and assignments, or other information necessary for the delegated claims operation to determine the medical necessity for the health care services provided.

Emergency services or out-of-area urgently needed services do not need authorization to be considered "complete," providing that the diagnoses codes or accompanying medical records substantiate that they qualify as emergent, urgent under the reasonable person standard.

Key Terms and Definitions *(cont'd.)*

Compliance

Compliance means conforming to a rule, such as a specification, policy, standard or law. Regulatory compliance describes the goal that organizations aspire to achieve in their efforts to ensure that they comply with relevant laws, policies, and regulations.

Contested Claims - Commercial

A contested claim is defined as a claim or portion thereof that is reasonably contested where the delegated claims operation has not received the completed claim and all information necessary to determine payor liability or has not been granted reasonable access to information concerning provider services. When appropriate, claims may need to be contested for additional information, e.g., medical records and chart notes. Contested claims include provider denials and claims pended or closed before a coverage determination can be made. Commercial contested claims must be adjudicated within 45 working days of the received date to be considered compliant.

Delegated Entity will be audited against and must maintain compliance with Claims Settlement Practices in accordance with Title 28 Section 1300.71(a)(8)(H) and (I) contesting claims for Medical Records.

(H) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to a plan or a plan's capitated provider by all providers over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with the section (a)(2). The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices.

(I) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the plan's or the plan's capitated providers for emergency room service and care over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with section (a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices.

Upon receipt of additional information, a new 45-working day cycle begins.

Key Terms and Definitions *(cont'd.)*

Date of Payment

The date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record.

Date of Receipt

Commercial

The working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's contracted Delegated Entity for that claim. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

Medicare Advantage

The working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, clearing house, or to the plan's contracted Delegated Entity. For Medicare Advantage, the earliest date, either from Blue Shield or any of the Blue Shield's Delegated Entities, determines the received date of the claim unless documentation can be provided to validate that the earliest stamp(s) does not belong to the Blue Shield network.

Delegated Entity

Any party who enters into a legal agreement by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.

HMO

Health Maintenance Organization. A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. Generally, an HMO will not cover out-of-network care except in an emergency or when authorized.

Incomplete Claims

A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which does not provide: "reasonably relevant information" and "information necessary to determine payor liability.

Key Terms and Definitions *(cont'd.)*

Medicare Advantage

The product line offered to enrolled members who have Medicare Part A and Part B and reside within the plan's service area.

Member Denial

An adverse benefit determination in which a claim, or any line item(s) on a claim, will not be paid and the member is responsible for payment of the service. Non-eligibility not authorized non-contracted, and/or excluded services are examples of potential member liability denials.

Closing a claim without issuing a payment is not a member denial unless the member is responsible for paying for the service rendered. A second denial notice may not be mailed to the member for the service provided.

Monitoring

Federal and state law specifically requires monitoring of compliance over Delegated Entities. Monitoring for compliance assesses the Delegated Entity's claims operation's ability to meet timeliness and accuracy requirements. Blue Shield reviews both the monthly and quarterly claims timeliness reports, conducts annual/periodic auditing as part of our compliance monitoring program and expects every Delegated Entity to monitor itself. Blue Shield expects the delegated claims operation to maintain a complete program of "continuous quality improvement" (CQI) to detect deficiencies early and implement corrective actions.

Principal Officer

Each Delegated Entity that has claims delegated must designate a Principal Officer for claims and provider disputes. These officers are responsible for attesting to compliant operations and for reporting the timeliness of those operations. The Principal Officer is the president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

The Principal Officer must sign the quarterly timeliness reports for both claims and provider disputes and Disclosure of Emerging Claims Payment Deficiencies. To designate an individual as Principal Officer or report a change of Principal Officer, request a form from the Blue Shield assigned claims auditor or retrieve the form from the HICE website and submit an original copy with original signatures to Blue Shield. The Principal Officer form should be submitted by email to ClaimsDelegateReport@blueshieldca.com.

Key Terms and Definitions *(cont'd.)*

Provider Dispute Resolution (PDR)

A written provider dispute that includes all information required under state regulations:

(1) Clear identification of the disputed item(s).

(2) The date of service(s)

(3) Clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, denial, or other action is incorrect.

Provider Dispute Resolution (PDR) Process - Commercial

A formal process for receiving, resolving, and reporting provider disputes for commercial claims relating to billing, claims, contracts, and utilization management is mandated for delegated payors.

Provider Dispute Resolution (PDR) Process - Medicare Advantage

A formal process for receiving, resolving, and reporting provider disputes for Medicare Advantage claims relating to payment non-contracted provider claims only.

Unaffiliated/Non-Contracted Provider

Commercial

A provider with whom the plan and/or its contracted Delegated Entity does not have a signed contractual agreement in place on the date of service (often referred to as a non-contracted or out of network provider). A contractual agreement can be an actual written contract, a one-time letter of agreement (LOA), a memorandum of understanding (MOU), or a provider rendering services while on-call or covering for a contracted provider. Delegated Entities may not utilize Blue Shield reciprocity and/or PPO rates without the written consent of the health plan. Commercial non-contracted provider claims must be adjudicated within 45 working days of the received date to be considered compliant.

Medicare Advantage

A provider with whom the plan and/or its Delegated Entities does not have a signed contractual agreement in place on the date of service (often referred to as a non-contracted or out of network provider). A non-contracted/unaffiliated provider's claim must be adjudicated within 30 calendar days from the earliest date received to be considered compliant.

Key Terms and Definitions *(cont'd.)*

Unclean Claims - Medicare Advantage

An "unclean claim" is defined as an incomplete claim, a claim that is missing any of the above information, or a claim that has been suspended in order to get more information from the provider.

Measuring Timeliness and Accuracy

Timeliness for claims and disputes is measured from the date the claim or provider dispute is received to the date the check or disbursement, explanation of benefits, denial notice, or dispute resolution correspondence is mailed.

Acknowledgement of Receipt

Commercial

The Delegated Entity must acknowledge receiving electronic claims within two (2) working days of date of receipt of the claim and paper claims within 15 working days of date of receipt of the claim.

Acknowledgement timeframes are based on the date of receipt. The acknowledgment date for electronic submission claims should be either the date the claim became available to the Delegated Entity from their clearing house or the date the claim arrived directly via direct electronic delivery.

Acknowledgement must be in the same manner as the claim was submitted or provided by electronic means, by phone, website, or another mutually agreed upon accessible method of notification. (CCR Title 28 Section 1300.71(c)).

Blue Shield will validate Delegated Entity/MSO website to assure that directions are provided for a non-contracted provider regarding how they can confirm receipt of claim.

Commercial Provider Dispute Resolution (PDR)

The Delegated Entity must acknowledge receiving electronic provider disputes within two (2) working days of receipt and paper provider disputes within 15 working days of receipt.

Measuring Timeliness and Accuracy *(cont'd.)*

Check Cashing Timeliness

Blue Shield accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented via a formal Policy and Procedure. As evidence that the check has been mailed, the Delegated Entity can provide a check mail log that has been signed by a Principal Officer or CFO who is attesting to checks being mailed on the dates reported. Blue Shield will confirm the date the check or electronic transfer was cleared to the Delegated Entity's bank account during the audit process. Blue Shield requires that a minimum of 70% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed. If the check clearing timeliness is below 70%, Blue Shield requires the Delegated Entity to submit a check cashing attestation to be completed by each provider. The attestation can be requested from your assigned claims delegation oversight auditor.

Fee Schedule Accuracy

Commercial

Contracted providers must be paid accurately at contracted rates. During a claims delegation audit, this is demonstrated by the Delegated Entity providing the header page and the signature page of the provider contract with the fee schedule and evidence of the system configuration.

Non-contracted providers may be paid at a reasonable and customary (R&C) fee schedule which requires the Delegated Entity as mandated by Title 28 CCR 1300.71(a)(3):

(B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and

(C) For non-emergency services provided by non-contracted providers to PPO enrollees: the amount set forth in the enrollee's Evidence of Coverage.

Measuring Timeliness and Accuracy *(cont'd.)*

Fee Schedule Accuracy *(cont'd.)*

Medicare Advantage

Title 42, Part 422, Section 214 mandates that "Any provider that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in a Medicare Advantage private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare."

Blue Shield will accept the following in determining accuracy on non-contracted 30-day claims based on the location of where the services were rendered:

(1) "Participating" providers are paid at a published Medicare fee schedule less any standard copayment amount,

(2) "Non-participating" providers who accept assignment are paid 95% of a published Medicare fee schedule less any standard copayment amount, and

(3) "Non-participating" providers who do not accept assignment are paid at the "Limiting Charge," This charge is the amount that non-participating providers are "limited" to charge for that service. The amount is 115% of the non-par fee allowance service.

Interest Accuracy

Commercial

Interest is applicable for contracted and non-contracted providers' claims paid later than the statutory deadline. Interest must be paid beginning with the first day after deadline through the day the payment/ check is mailed.

Interest is due on adjustments found in favor of the provider (in whole or in part) when the Delegated Entity was at fault with the original claim process. Interest would be calculated from the original received date of the claim through the date of the mailing of the adjustment payment.

The interest rate is fixed at a 15 percent annual rate. The amount of interest is calculated by multiplying the daily rate times the number of calendar days late, times the dollar amount paid. The interest should be included with the claim payment except as noted below.

To avoid a mandated $10.00 per claim penalty, the interest must be paid "automatically." Automatically means that the full amount of interest warranted must be included with the claim payment or mailed within five working days of the original claim payment. If the warranted amount of interest is underpaid, the mandated $10.00 per claim penalty must be paid along with the additional interest due.

Measuring Timeliness and Accuracy *(cont'd.)*

Interest Accuracy *(cont'd.)*

Commercial *(cont'd.)*

If the interest amount is less than $2.00 the interest may be paid on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid as long as a statement identifying the specific claims for which the interest being paid is included.

For claims involving emergency services, the minimum amount of interest due is the greater of either $15.00 for each 12-month period or 15 percent per annum calculated as described above.

Medicare Advantage

Clean claims from unaffiliated/non-contracted providers, including adjustments, in which the payor was at fault on the initial determination that are paid later than the statutory deadline requires interest to be paid. Interest is to be calculated beginning on the thirty-first calendar day through the day the check is mailed.

Interest is due at the current Federal Prompt Payment Interest Rate, which is updated each January and July. The current interest rate can be found at www.fiscal.treasury.gov/prompt-payment/rates.html.

Interest is to be calculated based on (1) the number of calendar days over thirty (30), (2) the current Medicare interest rate and (3) the amount paid. The daily rate is the result of dividing the interest rate in effect at the time the claim was paid by 365 or 366 in the case of a leap year.

The amount of interest is calculated by multiplying the daily rate, times the number of calendar days over 30, times the dollar amount paid. The interest should be included with the claim payment.

Measuring Timeliness and Accuracy *(cont'd.)*

Measuring Timeliness

Commercial Claims

Claim processing begins when a claim is first delivered to delegated payor's office. The number of days measured are "working" days. The time limit to make payment – 45 working days – applies to all claims, without regard to whether the billing provider is contracted or non-contracted. If a claim is to be contested, the notice to that effect must be mailed within 45 working days.

If a Management Service Organization (MSO), that manages several delegated entities, receives a claim from one of their post office boxes and loads the claim into the wrong Delegated Entity's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity's claim system.

Member denial notices must be mailed within 30 calendar days of receipt of the claim to fulfill the ERISA regulations. This policy blends requirements from ERISA regulations and the California Health and Safety Code. To fulfill the state regulations all denial notices must be mailed within 45 working days.

Commercial Provider Dispute Resolution

Resolution and a written determination must be completed within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. If the provider dispute is overturned in favor of the provider, payment is due within five (5) working days of the issuance of the written determination. If the payment is issued prior to the written determination, the written determination is due to the provider within five (5) working days of the issuance of the payment. Interest and penalties on disputes which result in determination in favor of the provider should be calculated beginning 45 working days following the date of receipt of the original complete claim.

Measuring Timeliness and Accuracy *(cont'd.)*

Measuring Timeliness *(cont'd.)*

Medicare Advantage Claims

Claim processing begins when a claim is received anywhere within a health plan if the claim was received first by the plan's contracted network, contracted clearing house and/or imaging vendor, or post office box of either the health plan or contracted network. If a Management Service Organization (MSO), that manages several delegated entities, receives a claim from one of their post office boxes and loads the claim into the wrong Delegated Entity's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity's claim system. The earliest date stamp on a claim determines when the timeliness cycle begins and must be entered into the claim system as the received date unless documentation can be provided to validate that the earliest stamp(s) does not belong to the Blue Shield contracted network. The number of days measured is "calendar" days. There are two different types of claims, each with its own processing time limit: 1) 30 calendar days for clean claims from unaffiliated/ non-contracted providers and 2) 60 calendar days for all other claims – "unclean" claims paid or denied from unaffiliated/non-contracted providers, or claims paid or denied from affiliated/contracted providers. The mailed date of the check and/or correspondence defines the end of the claim's turnaround time.

Medicare Advantage Provider Dispute Resolution for Non-Contracted Providers

Provider dispute resolution includes decisions where a non-contracted provider contends that the amount paid by the payor for a covered service is less than the amount that would have been paid under Original Medicare. Submission of a first level Provider Dispute must be filed within a minimum of 120 calendar days after the notice of initial determination. Resolution and a written determination must be completed within 60 calendar days after the date of receipt of the provider dispute. The non-contracted provider may submit a second level written request to Blue Shield within 180 calendar days of written notice from the payor. Second level disputes must be submitted to:

Blue Shield of California
Medicare Provider Appeals Department
P.O. Box 272640
Chico, CA 95927

The provider payment dispute process cannot be used to challenge denials by organizations that result in zero payment being made to the non-contracted provider. The payment dispute process may not be used to resolve payment disputes between contracted network providers and organizations covered by this process.

Measuring Timeliness and Accuracy *(cont'd.)*

Commercial Evidence of Payment (EOP)/Remittance Advice (RA)

Each Delegated Entity needs to include the following information in their EOP/RA:

- PDR Verbiage

  California Code of Regulations, Title 28 Sections 1300.7138 (b)
  - (b) Notice to Provider of Dispute Resolution Mechanism(s). Whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address for a filing a provider dispute.
  - The right to dispute a claim using the approved PDR request form.
  - The dispute must be submitted within 365 calendar days from last claim action.
  - Written determination of the dispute must be made consistent with applicable state and federal law, within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
  - A provider has the right to submit an appeal if they do not agree with this resolution of this claims dispute. The language should include "you have the right to appeal directly to Blue Shield of California within 60 working days from the Date of Determination." This appeal would only be for Medical Necessity *de novo* review.

Medicare Evidence of Payment (EOP)/Remittance Advice (RA)

Each Delegated Entity needs to include the following information in their EOP/RA:

- Denial Rights
- Waiver of Liability Statement
  - The Waiver of Liability statement can be downloaded from the CMS website at www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip
  - Per CMS, Delegated Entities cannot provide a link to the CMS web page and give the non-contracted provider the instructions to access the form
  - The EOP should have the waiver of liability link referenced above OR
  - Waiver of Liability link and form together

    Note: Delegated Entities CANNOT have the form only.
- Appeal Rights
- PDR Second Level Verbiage
  - "You have the right to dispute this decision directly with Blue Shield of California within 180 days from the determination of the payer."

Measuring Timeliness and Accuracy *(cont'd.)*

Member Denial Notice

Commercial

A denied claim is a claim where (1) one or more services will not be paid by the Delegated Entity's claims operation and (2) payment is the financial responsibility of the member.

Member denied claims are reported and monitored separately from paid and "contested" claims. Provider-denials are reported and audited along with other contested claims.

Examples of claims that are not member denials and should not be reported, submitted, or presented to Blue Shield as member liability "denied" claims include:

- Patients who remain enrolled with the health plan but have transferred from one Delegated Entity to another must be forwarded to the health plan or the other entity for processing;
- Duplicates to claims already paid or denied must be denied as duplicates, a second denial notice may not be mailed to the member;
- Encounter only, and capitated claims;
- Denials to a contracting provider who must write off the unpaid claim (unless the provider has written evidence that the member understood and accepted payment responsibility); or
- Reduced payment amounts due to contract terms, or correction of billing errors such as bundling or inaccurate coding.

Measuring Timeliness and Accuracy *(cont'd.)*

Member Denial Notice *(cont'd.)*

Medicare Advantage

A denied claim is a claim where (1) one or more services will not be paid by the provider claims operation and (2) payment is the financial responsibility of the member.

Examples of claims that are not member denials and should not be reported, submitted, or presented to the health plan as member liability "denied" claims include:

- Patients who remain enrolled with the Health Plan but have transferred from Delegated Entity to another and you are just forwarding the claim to the health plan or the other entity for processing;
- Patients who remain capitated to your organization, but payment responsibility belongs to another contracting entity (health plan or hospital), and you are forwarding the claim;
- Duplicates to claims already paid or denied;
- Encounter only, and capitated claims;
- Denials to a contracting provider who must write off the unpaid claim (unless the provider has written evidence that the member understood and accepted payment responsibility); or
- Correction of billing errors such as bundling or inaccurate coding.

Member Denial Notice – Standards

Commercial

When health plans and Delegated Entities make decisions to deny claims that result in liability for the enrollee, those decisions must be in accordance with DMHC and DOL law and regulations (ERISA), including required coverage for emergency care taking the "reasonable person" standard into account. The member must be given clear information including phone numbers and mailing addresses to assist them in contacting the health plan, the delegated claim operations, or the consumer assistance agencies for more information or to appeal the denial decision.

Once a denial notice has been sent, no further adverse notices may be sent to the member for the service provided.

All member emergency and non-emergency denial letters must include the denial code and denial reason. The denial reason code should match what is being submitted on the EOB/RA.

Measuring Timeliness and Accuracy *(cont'd.)*

Member Denial Notice – Standards *(cont'd)*

Denial letters sent to members should include Section 1557 of the Affordable Care Act of 2010 which prohibits discrimination based on race, color, national origin, sex, age, or disability in certain health programs and activities. Members must be notified about their rights under Section 1557. Specifically, delegated entities must include a nondiscrimination notice in English and taglines in at least the top 15 non-English languages spoken by individuals with limited English proficiency with every member liability denial notice.

Medicare Advantage

Federal law, regulations and CMS guidelines govern initial coverage determinations that are adverse to a Medicare beneficiary (i.e., denials that result in financial liability for the beneficiary).

These requirements apply to health plans and thereby to any entity in which authority to make coverage determinations has been delegated. When an adverse determination has been made, the current CMS approved Integrated Denial Notice (IDN) letter format must be sent to the member.

Any changes to Integrated Denial Notices will be sent out annually as applicable.

Each IDN letter should include Section 1557 of the Affordable Care Act of 2010 which prohibits discrimination based on race, color, national origin, sex, age, or disability in certain health programs and activities. Members must be notified about their rights under Section 1557. Specifically, covered entities must include a nondiscrimination notice in English and taglines in at least the top 15 non-English languages spoken by individuals with limited English proficiency with every Integrated Denial Notice.

All Integrated Denial Notices (IDN) must contain the Blue Shield Medicare Advantage plan CMS material identification number along with the CMS approved expiration date. The most current IDN letter may be obtained through the Blue Shield's Delegated Oversight Department - Claims.

If identified that the member is eligible with Blue Shield but assigned to another Delegated Entity, the claim must be forwarded to the appropriate payor or denied to the provider of service informing them that another payor is responsible. It is not the member's liability.

Medicare Advantage - Opt Out

Any provider that has chosen not to participate with the CMS Medicare program may not provide services to a Medicare member without notifying the member in advance that they have elected to opt out of the CMS Medicare program. Upon advanced notification, the member would be responsible for the payment of the services rendered.

Measuring Timeliness and Accuracy *(cont'd.)*

Overpayment

Commercial

The Delegated Entity has a total of 365 calendar days from the date of payment to initiate an overpayment request. The request must be in writing and allow the provider of service a minimum of 30 working days to contest and/or refund the overpayment. The Delegated Entity may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission when (1) the provider fails to reimburse within the 30-working day timeframe and (2) the provider has entered into a written contract specifically authorizing the Delegated Entity to offset an uncontested notice of overpayment of a claim from the contracted provider's current claims submissions.

Medicare Advantage

The Delegated Entity may go back three (3) years from the date the claim was paid to collect an overpayment. Once an overpayment is discovered and a final determination is made, a first written demand letter is sent. If a full payment is not received within 30 calendar days, interest accrues starting on day 31. If the provider agrees with the overpayment by day 15, recoupment can start. ff the provider sends a rebuttal follow the Medicare process. If the Delegated Entity has a written agreement with the provider to automatically off-set any overpayment(s) no written demand letter is required.

Payment Accuracy

Commercial

Payment accuracy includes: (1) proper payment of interest, (2) proper use of a reasonable and customary fee schedule for non-contracted providers, (3) applying appropriate contract fee schedules, and (4) system configuration All four criteria must be met for a claim or a claim provider dispute to be considered compliant in payment accuracy.

Medicare Advantage

Payment accuracy includes: (1) proper payment of interest and (2) proper use of provider fee schedules for non-contracted providers, and (3) system configuration The three criteria must be met for a claim or a claim provider dispute to be considered compliant in payment accuracy.

Measuring Timeliness and Accuracy *(cont'd.)*

Rescinding Authorization – AB 1324 (Health & Safety Code Section 1371.8)

Blue Shield validates that Delegated Entities pay incurred services if the specific service was pre-authorized or referred, even if the member is later found to be ineligible for any reason, when the provider of service relied on the authorization or referral in good faith and validated the eligibility of the member prior to service being rendered. If the Delegated Entity has an approved authorization and service has not been rendered, the Delegated Entity needs to formally rescind the authorization by sending a notice to the authorized rendering provider and to the member. The Delegated Entity can bill Blue Shield under the eligibility guarantee clause within their contract with Blue Shield if services were rendered by a provider who relied on the authorization in good faith.

Timely Filing

Commercial

The Department of Managed Health Care enacted regulations related to claims settlement and dispute resolution practices of health plans and their delegated IPA/medical groups ("AB 1455 Regulations"). Among other things, the AB 1455 Regulations provide timely filing limitations for commercial claims depending on the provider's status. Timeframes for filing claims for contracted and non-contracted providers are as follows:

- Contracted – A deadline of less than ninety (90) days after the date of service may not be imposed.
- Non-contracted – A deadline of less than one hundred eighty (180) days after the date of service may not be imposed

Medicare Advantage

- Claims with dates of service January 1, 2010 and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

Medicare Advantage Provider Dispute Resolution (PDR)/Appeal

The submission of a first level provider dispute/appeal must be filed within a minimum of 120 calendar days after the notice of initial determination (i.e., explanation of benefits, remittance advice, and/or letters). Additional filing requirements are as follows:

- Payor may allow an additional 5 calendar days for mail delivery
- The payor may extend the time limit for filing a provider dispute/appeal if good cause is shown

Measuring Timeliness and Accuracy *(cont'd.)*

Unclean or Contested Claims (Affiliated or Unaffiliated Providers)

Commercial (Contested)

The Delegated Entity may contest incomplete claims and disputes for missing information. The claim may either be pended and/or contested to the provider and may include a statement that it will receive no further attention if no reply is received. Contested claims are not to be reported as member denials. The contested or pended claims must be closed prior to the 45th working day. No denial notice should be sent to a member when "closing" a claim pending receipt of additional information.

Medicare Advantage (Unclean)

For Medicare Advantage claims, two separate attempts are recommended to obtain missing information allowing sufficient time for the provider to respond to each request and indicating the claim will be denied by the 60th calendar day if no response is received. By the 55th calendar day post receipt of the claim, an initial determination to pay or deny the claim must be made based on the information available.

Best Practices and Claim Adjudication

In this section as well as prior sections, the terms "our" or "your" refer both to health plans and to the Delegated Entity. Best practices are recommended for everyone involved in claims processing. When the word "must" is used, Blue Shield regards the standard as the requirement to be met.

Audits and Audit Preparation

Blue Shield, CMS, and the DMHC will conduct periodic audits of claims and provider disputes (where appropriate) to ensure compliance with all regulatory requirements. In advance of Blue Shield's audit, Blue Shield will send a written notification 60 days prior to the audit that includes the documents the Delegated Entity will need to provide along with the scope of the audit and due dates of when the material needs to be submitted. The documentation includes providing claims universes for each category. An industry standard questionnaire will need to be completed that will provide detailed information about your claims processing operations and internal controls. Also provided is a cover sheet that needs to be completed and attached to each claim sample. Note that the claim sample must include the following documentation from the contract with the provider: the first and last page (signature) and rate sheet. All documentation is required to be submitted with the sample claim as noted on the cover sheet.

Best Practices and Claim Adjudication *(cont'd.)*

Audits and Audit Preparation *(cont'd.)*

Blue Shield will perform an annual audit for claims and compliance oversight which include internal controls and IT system security. Blue Shield will provide a notification of the annual audit that includes the scope of the audit along with interviews of appropriate departments within the Delegated Entity's organization. Blue Shield will require a walk through and demonstration of the Delegated Entity's operations. This will include a demonstration of a life of a claim from end to end (mailroom to disposition of payment and/or denial) which will include operational systems and interviews with staff associated with specific functional areas. To assure end to end processes are formally documented, Blue Shield requires submission of Policy and Procedures (P&P) noted in the industry standard questionnaire as well as P&Ps requested during the audit claims assessment questions interview on the scheduled audit day. As part of the assessment, Blue Shield evaluates that P&Ps are reviewed annually via evidence that they were approved via committee or appropriate authority signature and dated.

If required claims documentation is not received, the audit is incomplete and will be scored as non-compliant and a corrective action plan (CAP) will be required by the Delegated Entity along with a follow up audit that will be scheduled. The Delegated Entity will be escalated to the Delegation Oversight Committee as non-compliant for lack of submission of audit documents. Electronic submission of all data is required.

Blue Shield will provide the Delegated Entity with written results within 30 days including an itemization of any deficiencies and whether or not the Delegated Entity must prepare and submit a formal, written corrective action plan to include root cause and remediation within 30 days of receipt of audit results or provide additional supporting documentation within time period provided by Blue Shield.

Regulatory Audit

In the event CMS or the DMHC require that Blue Shield conduct additional compliance oversight, Blue Shield will require the Delegated Entity to participate within the regulator-specified time schedules or deadlines and provide the material in the format requested in the timeframe as stipulated by the regulators. Refusal to do so will result in an escalation to the Delegation Oversight Committee.

Best Practices and Claim Adjudication *(cont'd.)*

Balance Billing

Commercial

California state law prohibits balance billing by contracted providers for all services and non-contracted providers of emergency services.

The California Code of Regulations identifies in Title 28 Section 1300.71 (g) (4) that every plan contract with a provider shall include a provision stating that except for applicable copayments and deductibles, a provider shall not invoice or balance bill a plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the plan or the plan's capitated provider for any covered benefit.

Except for services subject to the requirements of Section 1367.11 of the Act, "unfair billing pattern" includes balance billing by an emergency services provider.

If the provider continuously balance bills the member, the Delegated Entity should submit all written and documented verbal communication with the provider to the health plan who will report the provider to the Department of Managed Health Care (DMHC) for further action by the state. A non-contracted provider may appeal to the health plan directly should they disagree with the payment from the Delegated Entity.

AB 72

AB 72 (Health & Safety Code Section 1300.71.31. Methodology for Determining Average Contracted Rate; Default Reimbursement Rate) establishes a payment rate, which is the greater of the average of a health care service plan (health plan) or Delegated Entity contract rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services. The Delegated Entity must participate in the Independent Dispute Review Process (IDRP) and provide Blue Shield with the contact information to provide to the IDRP contractor managed by DMHC.

If the Delegated Entity fails to meet required timeframes for claims payment and Blue Shield determines that the claim is payable by the Delegated Entity, Blue Shield may pay the claim and deduct the amount of the payment from future capitation. When this occurs, Blue Shield will provide documentation explaining the deduction.

Best Practices and Claim Adjudication *(cont'd.)*

Balance Billing *(cont'd.)*

Medicare Advantage

Chapter 4 of the *Medicare Managed Care Manual*, Benefits and Beneficiary Protections, addresses when beneficiaries may be balanced billed, as identified below.

- Contracted providers are prohibited from balance billing enrollees. They may only collect the copayments and/or coinsurance.
- Non-contracting participating providers are prohibited from balance billing enrollees. They may only collect the copayments and/or coinsurance.
- Non-contracted non-participating providers can balance bill the health plan up to the original Medicare limiting charge.
- Non-contracted non-participating DME suppliers can balance bill the health plan the difference between the member's cost sharing and the DME supplier's bill.

Corrective Action/Follow Up Audits

Blue Shield performs, at a minimum, an annual claims and PDR audit. Follow-up audits will be scheduled by the assigned auditor if the Delegated Entity fails the annual audit. If applicable, as a result of a non-compliant follow-up audit, additional monitoring and/or remediation validation audits will be performed based upon outcome of escalation to the Delegation Oversight Committee. For those Delegated Entities who are subject to DMHC audits, if deficiencies are determined during the review, a corrective action plan (CAP) is required to be sent to Blue Shield by the date provided by the auditor. Additionally, Blue Shield may perform an unannounced audit dependent upon other indicators.

Date Stamping

Delegated Entities must date stamp all paper claims, including facsimiles, with the date the claim was received. The stamp should identify the specific Delegated Entity. Blue Shield recommends that each page of the paper claim including any attachments be date stamped. If a paper claim is received and then scanned for audit purposes, it should be batched for scanning by the original received date and include a unique identifier of the received date on the image.

For Medicare Advantage claims federal procedures suggest that claims received from the U.S. Postal Service after 4:30 PM may be considered "received" on the next business day. If a courier picks up the claims from the post office and transports them to the Delegated Entity's claims office, the time of pickup by the courier is what determines the date of receipt. The earliest received date by any Blue Shield Medicare Advantage HMO and PPO network provider must be utilized for Medicare Advantage claims.

Best Practices and Claim Adjudication *(cont'd.)*

Date Stamping *(cont'd.)*

For Commercial claims, date of receipt means the working day when a claim, by physical or electronic means, is first delivered to the Delegated Entity's post office box, claims office, or to a subcontractor who is responsible for receipt and processing of claims mail. The claims receipt date can also be the date the Delegated Entity receives a claim forwarded to them by either physical or electronic submission, as they have been determined to be the correct payor.

Disbursement of Payments

The date of payment is the date that the funds were electronically transferred (EFT) or the date the check was mailed via postal service to the provider. Blue Shield validates the EFT date as well as the date the payment was mailed. It is recommended that the Delegated Entity does not exceed 3 days from the paid date to the mail date. The additional mail processing days will be added into the claim's turnaround time calculation. Blue Shield will use the check mailed date as the closure of the claim's turnaround time. The Delegated Entity must provide a mail date policy and procedure to verify the additional days that have been included to validate turnaround time for audits.

Forwarding Claims (Misdirected for Commercial and Medicare Advantage)

Billing providers often submit claims and disputes to the incorrect payor. It is a requirement that the Delegated Entity forward claims directly to the financially responsible entity, if known, otherwise deny with a remit message informing the provider the Delegated Entity is not financially responsible for processing of the claim.

The misdirected claim's original received date is used to determine timeliness based upon how the claim was received first by the Delegated Entity's contracted clearing house(s) and/or imaging vendor(s), and/or post office boxes it owns.

If a Management Service Organization (MSO), that manages several Delegated Entities, receives a claim from one of their post office boxes and it loads the claim into the wrong Delegated Entity's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity's claim system.

Commercial Forwarding Timeliness

Regulations require the Delegated Entity to forward misdirected claims to the responsible payor within ten (10) working days of receipt.

Best Practices and Claim Adjudication *(cont'd.)*

Forwarding Claims (Misdirected for Commercial and Medicare Advantage) *(cont'd.)*

Medicare Advantage Forwarding Timeliness

The misdirected claim's, original received date is used to determine timeliness if the claim was received first by the plan contracted network, contracted clearing houses and/or imaging vendors, post office boxes of either health plans or contracted network.

Health plans and Delegated Entities should forward claims within ten (10) calendar days of initial receipt.

Monitoring of a Subcontractor (this includes MSO) for a delegated function-offshore/onshore

When the Delegated Entity engages a third-party administrator (TPA) or contracts with a management company to perform their claims processing, the Delegated Entity's contract with Blue Shield holds them ultimately responsible for claims compliance. Guidelines for sub-delegated functions are interchangeable within this section.

The Delegated Entity is expected to require the sub-delegated claims organization to meet all regulatory requirements and criteria discussed in this supplement. The Delegated Entity must perform the same tasks, e.g., delegation oversight of claims processing, that Blue Shield carries out as the Health Plan, including obtaining timely monthly reporting from them, and include their statistics in the Delegated Entities reports to Blue Shield. The Delegated Entity must audit the sub-delegated organization annually/periodically and require corrective action plan implementation when their performance results are not compliant. If the sub-delegated organization fails to achieve compliance, the Delegated Entity needs to take the appropriate actions to achieve compliance. If the Delegated Entity sub-delegates claims functions, they will need to demonstrate and provide evidence of their oversight of that entity during the on-site audit. If the Delegated Entity outsources claims functions, that will also need to be monitored.

The Delegated Entity must include claims-related regulatory and contractual provisions in contract agreements with other provider organizations.

The regulators require all health plans and their contracted delegated entities to demonstrate oversight and monitoring of any subcontractor that has sub-delegated operational functions that otherwise are audited by a health plan. "Subcontractor" refers to any organization that a sponsor contracts with to fulfill, or help fulfill, requirements of a delegated function. The term "offshore" refers to any country that is not one of the fifty United States or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). In providing oversight, Blue Shield requires all

Best Practices and Claim Adjudication *(cont'd.)*

Monitoring of a Subcontractor *(cont'd.)*

Delegated Entities to submit an annual offshore attestation and proof of an annual audit conducted on the offshore and/or onshore subcontractor. If commercial line of business is offshored, approval is required from Blue Shield prior to offshoring any Blue Shield commercial delegated claims.

Reopenings

A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process.

Reopenings are different from adjustment claims in that adjustment claims are subject to normal claims processing timely filing requirements (that is, filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (e.g., claim determinations may be reopened within one year of the date of the initial determination for any reason, or within one to four years of the date of the initial determination upon a showing of good cause).

Reference Materials for Reopenings

- 42 CFR 405.980
- MLN Matters Number SE 1426
- Medicare Manual Chapter 34
- Medicare Managed Care Manual Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance
- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912
- www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/ORGDetermin

Reporting

Claims Reports

Monthly/Quarterly self-reports must be submitted on the HICE industry-standard templates. Report templates and detailed instructions can be found in this appendix under the *Claims Delegate Reporting Instructions* section.

Compliance Program Effectiveness Oversight Audit

Delegation Oversight will perform an annual audit of the effectiveness of your organization's Compliance Program. The audit includes the assessment of the following:

- Compliance Program structure (the effectiveness of your organization's compliance program.
- Risk Bearing Organization (RBO) and Management Services Organization (MSO) ownership and hours of availability
- Training material and the training your organization conducts on all employees (including temporary and contracted employees)
- Implemented policies and procedures
- FWA reporting
- Monitoring and auditing internal risks
- Organization's internal controls and organization capacity structure

This audit will be performed either via Blue Shield Delegation Oversight Compliance Team individually on an annual basis or as a shared audit through HICE (Health Industry Collaborative Effort).

The Compliance audit evidence grid will be provided by the Delegation Oversight Auditor prior to the scheduled audit date. The grid should be used as a guide for audit documentation submission guidelines and as well as policy and business rules to assist with understanding the audit history and requirements. To download a copy of the Compliance Audit Evidence Grid, go to the Blue Shield provider website at www.blueshieldca.com/en/bsp/providers and navigate to the *Forms* section, then *Delegation oversight forms*. All requested documents from the evidence grid must be submitted to BSCandPHP_DOCPEAudit@blueshieldca.com.

For more information on the shared audit process and joining, please visit the HICE website at www.iceforhealth.org/teamactivities.asp.

Fraud

Fraud is the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s). An example of fraud is when a provider purposely bills for services that were never given or bills for a service that has a higher reimbursement than the service provided

Compliance Program Effectiveness Oversight Audit *(cont'd.)*

Abuse

Abuse includes, but is not limited to, the following improper behaviors or billing practices:

- Billing for a non-covered service;
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered);
- Inappropriate allocating costs on a cost report; or
- Payment for items or services that are billed by mistake by providers but should not be paid for by Medicare. This is not the same as fraud.

Compliance Program

Key components of a strong compliance program should include but are not limited to:

1. Written policies, procedures, and standards of conduct articulating the organization's commitment to comply with all applicable federal and state standards.
2. The designation of a compliance officer and compliance committee accountable to senior management.
3. Procedures for conducting claims compliance/internal control audits.
4. The procedures that will be taken to report the suspected fraud to Blue Shield.
5. Effective training and education between the compliance officer and the employees, managers, directors, and the downstream and related entities.
6. Effective lines of communication between the compliance officer, members of the compliance committee, the employees, managers and directors, and the downstream and related entities.
7. Enforcement of standards through well-publicized disciplinary guidelines.
8. Procedures for effective internal monitoring and auditing.
9. Procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives relating to the organization's contract.
10. Respond to and initiate corrective action to prevent similar offenses including a timely responsible inquiry.
11. Conduct timely and reasonable inquiries.
12. Conduct appropriate corrective actions in response to the potential violation.

Compliance Program Effectiveness Oversight Audit *(cont'd.)*

Compliance Program *(cont'd.)*

13. Include procedures to voluntarily self-report potential fraud or misconduct to the health plan, state, and federal regulators.
14. Development and implementation of regular, effective education, and training that occurs annually.
15. Retain records of the annual training of employees, including attendance logs and material distributed at training sessions.
16. Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded or precluded from participating in CMS programs.
17. Include a system to receive, record, and responds to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality. The Delegated Entity will report compliance concerns and suspected or actual misconduct without retaliation when reporting in good faith to Blue Shield.
18. Policy shall allow any state, federal government, or CMS to conduct on-site audits.
19. Performance of data analysis of procedures codes, diagnostic codes, utilization, quantity, etc., to detect fraud.
20. Ensure program includes the monitoring of claims for accuracy which includes ensuring coding reflects services provided.
21. Be able to produce proof to show compliance with all requirements.
22. Check the Office of Inspector General (OIG) and the General Services Administration (GSA) exclusion lists for all new employees and on a regular basis or at least once a year thereafter to validate that employees and other entities that assist in the administration or delivery of services are not included on such lists.
23. Check the Office of Inspector General (OIG) and the General Services Administration (GSA) exclusion lists for all providers on a regular basis to validate that the providers that assist in the administration or delivery of services are not included on such lists.

Compliance Program Effectiveness Oversight Audit *(cont'd.)*

Reporting

Please use one of the following ways to report fraud, waste, and abuse to Blue Shield:

- Call the Blue Shield 24-hour Anti-Fraud Hotline at (800) 221-2367. This hotline is managed by Blue Shield's Special Investigations Unit.
- Send an email to MedicareStopFraud@blueshieldca.com.
- Submit an inquiry via the internet at blueshieldca.com/fraud-report.

CMS and DMHC mandates that each health plan and its Delegated Entities have a Compliance, Fraud, Waste, and Abuse program in place and further mandates that all employees are required to take the training, at a minimum, annually. To ensure Blue Shield is meeting all CMS and DMHC requirements, Delegated Compliance Oversight will perform an annual review of each Delegated Entity's Compliance Program, including a Fraud, Waste, and Abuse program and assurance that all employees have taken Compliance Program training.

IT System Security

An IT system integrity audit will be conducted to assure system access controls, policy and procedures regarding system changes, security of data, etc. are maintained. The oversight is also performed either via shared audit through HICE or individually on a bi-annual basis with quarterly monitoring. Areas of overall concern to be reviewed include:

- Operational effectiveness
- Access to programs and data access rights definition
- Access to programs and data access control mechanisms and password complexity
- Program changes/standard change management
- Computer operations (backup, recovery, and resumption)/HIPAA compliance
- Program changes
- Access to IT privileged functions

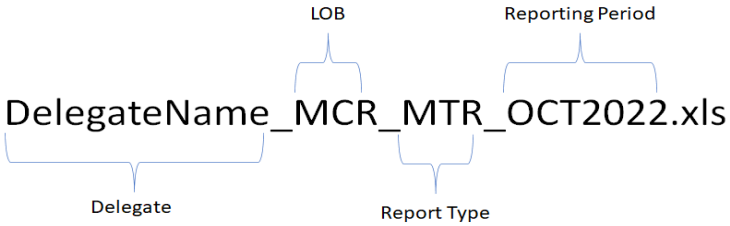
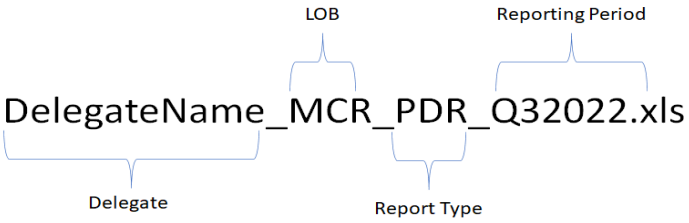
Oversight Monitoring

Delegated Entity shall implement controls to ensure internal processes are monitored for integrity of mechanisms and procedures to promote accountability and prevent fraud.

- Group shall not allow the same person or departments to have the ability to pay claims and enter or update new providers, vendors and/or eligibility;
- Group shall provide staffing levels and organizational capacity to ensure operations are consistent and maintained at all times;
- Group shall maintain a compliance program, and that the program is independent of fiscal and administrative management;
- Group shall ensure personnel have appropriate access to data, consistent with their job requirements; and
- Group shall ensure that any and all changes made to data contained in entities; databases are logged and audited.

Claims Delegate Reporting Instructions

Report Submission	
Submit Reports To:	ClaimsDelegateReport@blueshieldca.com
Report Template:	Submit results using Blue Shield of CA or BSC Promise report template.
Report Format:	If submitting an Adobe PDF in order to satisfy the Designated Principal Officer signature requirements, please also submit the report on the original Excel template.

Report Naming Convention	
	
	
Delegate	The delegated entity's name or an acronym which represents the group.
LOB	COMM (Commercial) MCR (Medicare) MCL (Medi-Cal) CMC (Cal Medi-Connect)
Report Type	DECD (Disclosure of Emerging Claim Deficiencies MTR (Monthly Timeliness Reporting) PDR (Provider Dispute Resolution) POF (Principal Officer Form)
Reporting Period	Identify the period being reported on e.g., OCT2022, Q32022, etc.

Designated Principal Officer	
Who Can Sign:	Results for the quarter must be attested to/signed by a Designated Principal Officer. The person attesting to the accuracy and completeness of the report must be an executive of the organization, Vice President level of above.

Claims Delegate Reporting Instructions *(cont'd.)*

Reports

Review all the Monthly/Quarterly report requirements. Please submit the Excel/Word report in addition to the signed document. Reports that do not meet reporting standards or have issues will be returned with a request to correct the inconsistencies. Prompt submission is expected to ensure timely reporting.

1. Disclosure of Emerging Claim Deficiencies

In accordance with the California Code Regulation (Title 28, Section 1300.71-Claims Settlement Practices), delegated entities that report claims deficiencies, must complete a Disclosures of Emerging Claims Payment Deficiencies form. The delegated entity will identify the reason for such reported deficiencies by selecting series of check mark boxes, which explain the lack or thereof compliance during the reporting period.

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Commercial	Claims Settlement Practice reports are submitted quarterly. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 30th • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year.	Blue Shield Provider Connection under *Delegation oversight forms*

Claims Delegate Reporting Instructions *(cont'd.)*

2. Monthly Timeliness Report (MTR) (Commercial)

Claims must be processed within 45 working days.

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Commercial	Reports are submitted monthly. The reports are due by the 15th of the month following the end of the reported month. If the 15th of the month falls on a weekend or holiday, the reports are due the next business day. At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • January report due February 15th • February report due March 15th • Q1 report due April 31st • April report due May 15th • May report due June 15th • Q2 report due July 31st • July report due August 15th • August report due September 15th • Q3 report due October 31st • Oct report due November 15th • November report due December 15th • Q4 report due January 31st of the following year	Blue Shield Provider Connection under *Delegation oversight forms*

Claims Delegate Reporting Instructions *(cont'd.)*

3. Monthly Timeliness Report (MTR) (Medicare)

Note: CMS Contract Numbers H0504 and H5928 are reported together under Blue Shield.

The Claims Monthly Timeliness Report is designed to report, without duplication, actions completed (i.e., claims finalized during each month). It includes claims finalized during the month being reported. Plans are to report requests for payment and services, as described in the Part C Technical Specifications, for non-contracted providers and enrollee representative. Do not include:

- Adjustments to previously paid claims
- Interest-only payments
- Claims forwarded to the financially responsible entity for payment
- Duplicate claims
- Encounter-only claims for services sub-capitated to other providers, or claims paid solely as a means of allocating capitation (and the member could never be liable for a denial)

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Medicare	Reports are submitted monthly. The reports are due by the 15th of the month following the end of the reported month. If the 15th of the month falls on a weekend or holiday, the reports are due the next business day. At the end of each reporting quarter, submit a report for the full quarter, include the "ClaimSource," "EnrolleeSource" and "ReopeningSource" tabs. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • January report due February 15th • February report due March 15th • Q1 report due April 31st • April report due May 15th • May report due June 15th • Q2 report due July 31st • July report due August 15th • August report due September 15th • Q3 report due October 31st • October report due November 15th • November report due December 15th • Q4 report due January 31st of the following year	Blue Shield Provider Connection under *Delegation oversight forms*

Claims Delegate Reporting Instructions *(cont'd.)*

4. Payment Dispute Resolution (PDR) (Commercial)

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Commercial	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 31st • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year	Blue Shield Provider Connection under *Delegation oversight forms*

5. Payment Dispute Resolution (PDR) (Medicare)

Note: CMS Contract Numbers H0504 and H5928 are reported together under Blue Shield.

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Medicare	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 31st • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year	Blue Shield Provider Connection under *Delegation oversight forms*

Claims Delegate Reporting Instructions *(cont'd.)*

6. Principal Officer Form

The Principal Officer is the president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

Line of Business (LOB)	Due Date	Report Location
All LOBs	Reports are due by the end of September each year (annually). Also, submit updated reports whenever changes occur to Principal Officer(s) at the delegated entity.	Blue Shield Provider Connection under *Delegation oversight forms*

7. Organization Determinations, Appeals, and Grievances (ODAG)

- Include all requests processed as both contract and non-contract provider denied claims and only non-contract provider paid claims.
- Exclude all requests processed as direct member reimbursements, dismissals, duplicate claims, and payment adjustments to claims, reopenings, claims denied for invalid billing codes, denied claims for beneficiaries who are not enrolled on the date of service, withdrawn requests and claims denied due to recoupment of payment.
- Submit payment organization determinations (claims) based on the date the claim was paid, or should have been paid, or the notification date of the denial, or the date the denial notification should have been sent (the date the request was initiated may fall outside of the review period).
- If a claim has more than one line item, include all of the claim's line items in a single row and enter the multiple line items as a single claim.

Line of Business (LOB)	Due Date	Report Location
Medicare	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the 15th of the month following the end of the reported quarter. If the 15th falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 15th • Q2 report due July 15th • Q3 report due October 15th • Q4 report due January 15th of the following year	Blue Shield Provider Connection under *Delegation oversight forms*

Qualifying Medical Benefit Drug Claims Submission Instructions

Box #	Instruction
1-24 C	Follow CMS 1500 Claim Form Instructions.
24 D	Provide the appropriate Blue Shield HCPCS or CPT Code based on the drug and dosage being billed. Include the National Drug Code (NDC), description, and total dosage provided for drugs.
24 E – 24 F	Follow CMS 1500 Claim Form Instructions.
24 G	Provide the total units provided per date of service and procedure code billed. Example: If 1000 mgs of Rituxan was provided on 09/01/00, then procedure J9310 (Rituxan 100 mg) would be billed with 10 units of service.
24 H – 24 J	Follow CMS 1500 Claim Form Instructions.
25	Enter the IPA's Federal Tax Identification Number.
26 – 32	Follow Sample CMS 1500 Claim Form Instructions.
33	Enter the IPA's Name, Address, Phone Number, and five-digit IPA Number preceded by IPA0. Example: Name of IPA, 123 Any Street, Any Town, CA 12345, 999-999-9999, IPA012345

Note: Claims for qualifying immunizations and injectables must not be combined with any other services on the claim form and must be submitted separately from encounter data.

Qualifying Medical Benefit Drug Claims Submission Instructions

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Development of Actuarial Cost Model

Actuarial Cost Model discloses the projected utilization rate, unit cost, and per-member per-month (pmpm) information for each type of service for commercial lines of business. These assumptions were developed based on actuarial projections and supplemented with Blue Shield actual experience. The actual experience for each medical group will deviate from these tables. Models were developed to reflect the costs for calendar year 2024 and are inclusive of services that the IPA/Group and/or Blue Shield of California bear responsibility for.

Individual and Group Plans are combined for reporting purposes since for most IPAs Individual members account for less than 1% of the overall commercial membership. Blue Shield is providing the following Actuarial Cost Models:

Attachment 1:	Individual and Group Plans 2024
Attachment 2:	Small Group Plans 2024
Attachment 3:	Large Group Plans 2024
Attachment 4:	Point of Service 2024

Source of Data

The fee-for-service claim experience data is extracted from Blue Shield of California's claims database. It reflects the overall claims experience incurred for each market segment and is trended to the center date 7/1/24 for calendar year 2024.

Actuarial Methodology

The projected utilization rates, unit cost and allowed pmpm costs for hospital inpatient, hospital outpatient and prescription drugs were developed based on the actual fee-for-service incurred claims. The allowed pmpm costs in the attachments are prior to member cost share. Appropriate trend factors were used to estimate claims for calendar year 2024. For professional services and other ancillary services such as home health, ambulance, or DME, the utilization rates and unit cost were estimated based on the commercial fee-for-service population and adjusted to reflect Blue Shield members' age/sex mix, geographical distribution, provider reimbursement, and benefit structure. The overall pmpm was reconciled to Blue Shield overall capitation paid in year 2022 and trended to 2024.

Attachment 1

Actuarial Cost Model - BSC HMO
Individual and Family Plans
Center Date: 07/01/2024

Service Category	Annual Admits per 1,000	Length of Stay	Annual Util. per 1,000	Average Cost Per Service	*Per Member Monthly Claim Cost*
Inpatient Hospital					
Medical	13.03	5.060	65.94	$ 8,118.55	$ 42.38 - $ 46.84
Surgical	7.91	6.592	52.17	12,968.56	53.56 - 59.20
Maternity	6.34	2.608	16.54	6,265.51	8.20 - 9.07
Psychiatric	1.11	8.029	8.94	3,330.22	2.36 - 2.61
Alcohol/Drug - Detox	3.79	3.414	12.93	3,634.77	3.72 - 4.11
SNF	0.97	1.306	1.27	14,100.43	1.41 - 1.56
Other	1.48	6.295	9.31	8,044.93	5.93 - 6.55
Subtotal					**$ 117.57 - $ 129.94**
Outpatient Hospital					
Emergency Room			118.64	$ 3,741.94	$ 35.15 - $ 38.84
Outpatient Surgery (Hosp & ASC)			57.63	4,855.80	22.15 - 24.49
Radiology			143.26	1,723.02	18.51 - 22.63
Pathology			195.64	345.91	5.08 - 6.20
PT/OT/ST			86.33	336.47	2.18 - 2.66
Other			114.65	1,239.35	11.25 - 12.43
Subtotal					**$ 94.31 - $ 107.26**
Physician					
Inpatient Surgery			67.90	$ 779.84	$ 3.97 - $ 4.85
Outpatient Surgery			892.10	220.95	14.78 - 18.07
Inpatient Visits			292.94	184.79	4.06 - 4.96
Office Visits & Misc.			3,503.18	89.56	23.53 - 28.76
Therapeutic Injections			326.53	670.21	16.41 - 20.06
Prof ER Visits			127.37	313.83	3.00 - 3.66
Radiology			457.11	143.33	4.91 - 6.01
Pathology			2,758.95	33.24	6.88 - 8.41
Immunizations			453.57	82.64	2.81 - 3.44
Speech / Hearing Exams / Vision Exams			823.88	62.12	3.84 - 4.69
Physical Exams / Well Baby Exam			717.68	76.85	4.14 - 5.06
Podiatrist			-	-	- - -
Outpatient MHCD			981.57	118.25	9.19 - 10.16
Maternity			31.28	802.15	1.88 - 2.30
Other			2,988.82	31.21	7.00 - 8.55
Subtotal					**$ 106.40 - $ 128.97**
Prescription Drugs			13,375.98	$ 111.78	**$ 118.36 - $ 130.82**
Other					
PDN / Home Health			-	$ -	$ - - $ -
Ambulance			23.05	1,418.70	2.45 - 3.00
DME			138.31	161.78	1.68 - 2.05
Prosthetics			1.50	817.06	0.09 - 0.11
Other			367.87	282.52	7.79 - 9.53
Subtotal					**$ 12.02 - $ 14.69**
Total Claims/Benefit Cost					**$ 448.66 - $ 511.68**

Attachment 2

Actuarial Cost Model - BSC HMO
Small Group Plans
Center Date: 07/01/2024

Service Category	Annual Admits per 1,000	Length of Stay	Annual Util. per 1,000	Average Cost Per Service	*Per Member Monthly Claim Cost*
Inpatient Hospital					
Medical	8.58	4.687	40.20	$ 8,181.09	$ 26.03 - $ 28.77
Surgical	5.30	5.684	30.10	13,632.78	32.48 - 35.90
Maternity	6.29	2.672	16.81	7,056.84	9.39 - 10.38
Psychiatric	1.50	5.111	7.65	3,878.97	2.35 - 2.60
Alcohol/Drug - Detox	1.73	3.084	5.33	4,319.89	1.82 - 2.01
SNF	0.38	0.965	0.36	25,645.86	0.74 - 0.82
Other	1.63	6.260	10.19	8,489.81	6.85 - 7.57
Subtotal					**$ 79.67 - $ 88.05**
Outpatient Hospital					
Emergency Room			87.97	$ 3,653.10	$ 25.44 - $ 28.12
Outpatient Surgery (Hosp & ASC)			38.21	6,691.74	20.24 - 22.37
Radiology			101.71	1,982.94	15.13 - 18.49
Pathology			159.79	395.35	4.74 - 5.79
PT/OT/ST			61.32	366.97	1.69 - 2.06
Other			69.87	1,527.56	8.45 - 9.34
Subtotal					**$ 75.69 - $ 86.17**
Physician					
Inpatient Surgery			40.39	$ 838.12	$ 2.54 - $ 3.10
Outpatient Surgery			628.49	263.28	12.41 - 15.17
Inpatient Visits			151.12	228.44	2.59 - 3.16
Office Visits & Misc.			2,776.34	101.98	21.23 - 25.95
Therapeutic Injections			169.96	756.80	9.65 - 11.79
Prof ER Visits			97.18	288.64	2.10 - 2.57
Radiology			453.16	161.64	5.49 - 6.71
Pathology			2,899.83	38.06	8.28 - 10.12
Immunizations			496.99	92.43	3.45 - 4.21
Speech / Hearing Exams / Vision Exams			645.50	78.85	3.82 - 4.67
Physical Exams / Well Baby Exam			712.82	88.19	4.72 - 5.76
Podiatrist			-	-	- - -
Outpatient MHCD			1,314.10	118.96	12.38 - 13.68
Maternity			33.18	1,006.28	2.50 - 3.06
Other			2,219.12	40.37	6.72 - 8.21
Subtotal					**$ 97.87 - $ 118.17**
Prescription Drugs			9,637.05	$ 137.12	**$ 104.62 - $ 115.63**
Other					
PDN / Home Health			-	$ -	$ - - $ -
Ambulance			17.80	1,413.88	1.89 - 2.31
DME			137.33	162.37	1.67 - 2.04
Prosthetics			1.14	798.42	0.07 - 0.08
Other			401.15	195.46	5.88 - 7.19
Subtotal					**$ 9.51 - $ 11.62**
Total Claims/Benefit Cost					**$ 367.35 - $ 419.65**

Attachment 3

Actuarial Cost Model - BSC HMO
Large Group Plans
Center Date: 07/01/2024

Service Category	Annual Admits per 1,000	Length of Stay	Annual Util. per 1,000	Average Cost Per Service	*Per Member Monthly Claim Cost*
Inpatient Hospital					
Medical	10.42	4.829	50.31	$ 8,516.22	$ 33.92 - $ 37.49
Surgical	6.66	5.796	38.61	14,953.13	45.70 - 50.52
Maternity	7.23	2.791	20.18	7,251.95	11.59 - 12.80
Psychiatric	2.08	6.561	13.65	2,674.56	2.89 - 3.19
Alcohol/Drug - Detox	1.68	3.722	6.26	3,054.33	1.51 - 1.67
SNF	0.51	5.296	2.68	3,925.35	0.83 - 0.92
Other	1.92	8.971	17.21	11,259.66	15.34 - 16.95
Subtotal					**$ 111.78 - $ 123.55**
Outpatient Hospital					
Emergency Room			128.58	$ 3,719.10	$ 37.86 - $ 41.84
Outpatient Surgery (Hosp & ASC)			55.85	7,223.49	31.94 - 35.30
Radiology			146.21	1,686.92	18.50 - 22.61
Pathology			218.61	363.46	5.96 - 7.28
PT/OT/ST			123.12	327.48	3.02 - 3.70
Other			117.93	1,485.17	13.87 - 15.33
Subtotal					**$ 111.14 - $ 126.06**
Physician					
Inpatient Surgery			51.24	$ 905.74	$ 3.48 - $ 4.25
Outpatient Surgery			792.02	299.75	17.81 - 21.76
Inpatient Visits			189.82	228.69	3.26 - 3.98
Office Visits & Misc.			3,800.86	103.85	29.60 - 36.18
Therapeutic Injections			196.72	837.17	12.35 - 15.10
Prof ER Visits			145.68	260.03	2.84 - 3.47
Radiology			555.44	162.98	6.79 - 8.30
Pathology			3,245.32	38.15	9.28 - 11.35
Immunizations			689.48	92.66	4.79 - 5.86
Speech / Hearing Exams / Vision Exams			822.30	84.48	5.21 - 6.37
Physical Exams / Well Baby Exam			1,045.52	90.70	7.11 - 8.69
Podiatrist			-	-	- - -
Outpatient MHCD			1,670.07	119.51	15.80 - 17.46
Maternity			38.79	1,148.73	3.34 - 4.08
Other			2,786.53	48.21	10.08 - 12.31
Subtotal					**$ 131.74 - $ 159.17**
Prescription Drugs			8,691.18	$ 154.51	**$ 106.31 - $ 117.50**
Other					
PDN / Home Health			-	$ -	$ - - $ -
Ambulance			24.50	1,089.29	2.00 - 2.45
DME			218.07	161.55	2.64 - 3.23
Prosthetics			1.75	863.83	0.11 - 0.14
Other			453.46	50.02	1.70 - 2.08
Subtotal					**$ 6.46 - $ 7.89**
Total Claims/Benefit Cost					**$ 467.44 - $ 534.18**

Attachment 4

Actuarial Cost Model - BSC HMO
Point of Service
Center Date: 07/01/2024

Service Category	Annual Admits per 1,000	Length of Stay	Annual Util. per 1,000	Average Cost Per Service	*Per Member Monthly Claim Cost*
Inpatient Hospital					
Medical	9.23	4.192	38.67	$ 6,507.66	$ 19.92 - $ 22.02
Surgical	5.39	5.135	27.68	12,060.03	26.43 - 29.21
Maternity	7.16	2.585	18.50	6,275.34	9.19 - 10.16
Psychiatric	2.08	6.561	13.65	2,674.56	2.89 - 3.19
Alcohol/Drug - Detox	1.68	3.722	6.26	3,054.33	1.51 - 1.67
SNF	-		-	-	- - -
Other	2.16	5.948	12.83	8,210.58	8.34 - 9.22
Subtotal					**$ 68.28 - $ 75.46**
Outpatient Hospital					
Emergency Room			121.76	$ 2,919.41	$ 28.14 - $ 31.10
Outpatient Surgery (Hosp & ASC)			57.73	4,902.81	22.41 - 24.77
Radiology			130.07	1,686.92	16.46 - 20.11
Pathology			194.49	363.46	5.30 - 6.48
PT/OT/ST			109.53	327.48	2.69 - 3.29
Other			123.32	2,735.04	26.70 - 29.51
Subtotal					**$ 101.70 - $ 115.26**
Physician					
Inpatient Surgery			49.19	$ 905.74	$ 3.34 - $ 4.08
Outpatient Surgery			760.22	299.75	17.09 - 20.89
Inpatient Visits			182.20	228.69	3.12 - 3.82
Office Visits & Misc.			3,648.24	103.85	28.41 - 34.73
Therapeutic Injections			188.82	837.17	11.86 - 14.49
Prof ER Visits			139.83	260.03	2.73 - 3.33
Radiology			540.63	162.98	6.61 - 8.08
Pathology			3,158.80	38.15	9.04 - 11.05
Immunizations			661.79	92.66	4.60 - 5.62
Speech / Hearing Exams / Vision Exams			789.28	84.48	5.00 - 6.11
Physical Exams / Well Baby Exam			1,003.54	90.70	6.83 - 8.34
Podiatrist			-	-	- - -
Outpatient MHCD			1,670.07	119.51	15.80 - 17.46
Maternity			37.23	1,148.73	3.21 - 3.92
Other			2,674.64	48.21	9.67 - 11.82
Subtotal					**$ 127.31 - $ 153.75**
Prescription Drugs			12,710.32	$ 143.47	**$ 144.36 - $ 159.56**
Other					
PDN / Home Health			-	$ -	$ - - $ -
Ambulance			23.85	1,089.29	1.95 - 2.38
DME			212.25	161.55	2.57 - 3.14
Prosthetics			1.71	863.83	0.11 - 0.14
Other			453.32	117.77	4.00 - 4.89
Subtotal					**$ 8.63 - $ 10.55**
Total Claims/Benefit Cost					**$ 450.28 - $ 514.59**

2024 Actuarial Cost Model

"Disclaimers:

The information presented herein regarding cost and utilization is provided by way of example only and is based broadly on historical data in Blue Shield's possession. It is not a statement of fact or opinion of what will actually occur and is not offered as an accurate predictor of the experience of any specific IPA/medical group. It is not intended to reflect the actual cost or utilization incurred by any specific IPA/medical group, does not predict the actual costs to any specific group or patient mix, and has not been risk adjusted in any way (capitation adjustments for age, sex, and benefit plan design are reflected in Exhibit C of the Agreement). Each IPA/medical group recognizes that its actual utilization and unit costs will likely differ from the examples given and could be higher or lower. Each IPA/medical group should not rely on this information in evaluating its own financial risk, but, rather, should review its own patient mix, utilization, and cost information as well as other available information, consult with its own financial and actuarial advisors in evaluating the information contained herein, and make its own independent business judgment in deciding to enter into the financial risk arrangements under the Agreement based on its own independent assessment."

Evaluation & Management (E&M) Codes

E&M Codes Visit Definition – List of procedure and revenue codes used to measure complete encounter submissions (see Section 4.4 Claims Administration, Performance - Regular and Complete Submission of Encounter Data). Codes are used to calculate the number of E&M visits per member per year (PMPY).

Procedure Codes			
92002	99243	99336	99393
92004	99244	99337	99394
92012	99245	99341	99395
92014	99304	99342	99396
99201	99305	99343	99397
99202	99306	99344	99401
99203	99307	99345	99402
99204	99308	99347	99403
99205	99309	99348	99404
99211	99310	99349	99411
99212	99315	99350	99412
99213	99316	99381	99415
99214	99318	99382	99416
99215	99324	99383	99420
99217	99325	99384	99429
99218	99326	99385	99461
99219	99327	99386	G0402
99220	99328	99387	G0438
99241	99334	99391	G0439
99242	99335	99392	

Evaluation & Management (E&M) Codes

Revenue Codes	
0510	0523
0511	0524
0512	0525
0513	0526
0514	0527
0515	0528
0516	0529
0517	0762
0519	0770
0520	0771
0521	0982
0522	0983