

PremierBlue

PROFESSIONAL POLICIES AND PROCEDURES

The purpose of Premier Blue policies and procedures is to provide specific explanations of provisions contained within the contracting provider agreements. This information is intended to supplement and further clarify the Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) policies and procedures (#1-3 and 5-12, Ambulatory Surgery Centers, Home Medical Equipment, and Dental) contractual obligations. These guidelines have been approved by the Premier Blue Board of Directors.

I. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

According to the HIPAA Privacy Rule (45 CFR 160, 164) as amended August 14, 2002, health care providers can disclose protected health information (“PHI”) to health plans pertaining to credentialing, retrospective review, office record reviews, and HEDIS (Health Plan Employer Data and Information Set) data collection for the following types of health care operations:

1. Quality assurance and quality improvement activities
2. Accreditation activities (e.g., HEDIS data collection)
3. Case management, care coordination, and related functions
4. Disease management
5. Protocol development
6. Credentialing
7. Provider or health plan performance evaluation
8. Training
9. Certification
10. Licensing

Providers are permitted by HIPAA to disclose PHI to health plans for the above purposes without authorization from the patient when both the provider and health plan have or had a relationship with the patient and the information relates to that relationship. (45 CFR 164.506[c][4]).

Premier Blue will follow any future changes to HIPAA privacy rules regarding protected health information.

II. CREDENTIALING

The contracting provider agreements require providers to cooperate with quality of care policy and procedures. An integral component of quality of care is credentialing of participating providers. This process consists of two parts: credentialing and recredentialing.

A. Credentialing

This process consists of an initial full review of the provider's credentials at the time of application.

1. The packet is completed by the applicant and submitted to Premier Blue for approval.
2. Upon receipt of the completed packet, correspondence is initiated with the appropriate licensing board(s), the Health Care Stabilization Fund, National Practitioners Data Bank, all hospitals/health care facilities, education, and specialty practice boards with which the provider has been or is affiliated.
3. The Quality Improvement (QI) staff will review the credentials packet to ascertain compliance with the following credentials criteria:
 - a. Graduation with a D.O. or M.D. degree from an osteopathic or medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education of the American Medical Association, or a medical school approved by the American Osteopathic Association, or a medical school approved by the Education Council for Foreign Medical Graduates, or a dental school approved by the American Dental Association, or a medical school approved by the Royal College of Physicians and Surgeons of Canada.
 - b. Current and unrestricted license to practice medicine in Kansas. The credentials committee has the authority to make exceptions for a “restricted license” where the restriction does not interfere with providing quality care to our membership.
 - c. Primary care physicians (PCP) must supply documentation of successful completion of three years postgraduate training or board certification in primary specialty of family practice, general internal medicine, general practice, or general pediatrics. In lieu of educational requirement, equivalent experience may be considered based on work history, interview, and recommendations. Board certification is strongly recommended.
 - d. Referral physician providers must supply documentation of successful completion of postgraduate training that satisfies requirements of the appropriate specialty board. Board certification is strongly encouraged.

- e. In order to participate in Premier Blue, a provider must participate in the Competitive Allowance Program (CAP) of BCBSKS and be in agreement to complete regular credentialing forms.
- f. Agreement to participate in quality of care and utilization review programs of Premier Blue.
- g. The initial office site assessment (OSA) confirms that the office and medical record keeping practices are in conformance with Premier Blue standards.
- h. Agreement to maintain a comprehensive medical record on each Premier Blue member/patient.
- i. Current and unrestricted Drug Enforcement Agency (DEA) number as appropriate for practice. The credentials committee has the authority to make exceptions to a restriction on a DEA number, when the restriction does not interfere with providing quality care to our membership.
- j. Current unrestricted hospital staff clinical and admitting privileges for the declared primary specialty and no restrictions due to a disciplinary action based on professional competence, adherence to appropriate standards of medical care, health status or other parameters agreed upon by the medical staff for any other privileges granted by a Premier Blue contracting/participating hospital within the service area. Physicians without admitting privileges may be approved, if there is evidence of an established referral process to assure access of inpatient care, or if the physician can provide coverage for required hospital care, twenty-four (24) hours per day, seven (7) days per week. This exception DOES NOT apply to those physicians who have lost admitting or clinical privileges due to disciplinary measures, or who have voluntarily resigned privileges to avoid loss of privileges or other disciplinary measures.
- k. Current professional liability coverage, which meets or exceeds minimum limits established by State of Kansas.
- l. Absence of history of involvement in a malpractice suit(s), arbitration, or settlement. In the case of an applicant with such history, evidence that this history does not demonstrate probable future substandard professional performance.
- m. Specialty appropriate coverage/timely access by a Premier Blue participating provider is arranged by the physician 24 hours per day, 7 days per week. Exceptions may be given, based on geographic location and at the sole discretion of BCBSKS.

- n. Absence of patterns of behavior to suggest quality of care concerns.
- o. Utilization review pattern consistent with peers in designated primary specialty and congruent with needs of managed care.
- p. No sanctions placed upon him/her by Medicaid, Medicare or debarred by Federal Employee Health Benefit Program. If applicant has such history, applicant will be denied credentialing if applicant: (1) is currently excluded, suspended, debarred, or otherwise ineligible to participate in any state or federal health care programs, including but not limited to Medicare, Medicaid, or Federal Employee Health Benefit program or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a state or federal health care program, after a period of exclusion, suspension, debarment, or ineligibility.
- q. Absence of a history of disciplinary actions affecting applicant's professional license, DEA number, or other required certification. For applicants with such history, evidence that this history does not currently affect applicant's ability to perform professional duties, for which the applicant is contracted, or does not demonstrate probable future substandard performance.
- r. No felony or misdemeanor convictions to include repeated driving under influence (DUI) or drug related arrests, which could affect applicant's current ability to perform the professional duties for which the applicant is contracted and does not demonstrate probable future substandard care.
- s. No current drug or alcohol abuse. Absence of a history of chemical dependency/substance abuse. For those applicants who have such history, evidence that the applicant is participating in or has completed a prescribed, monitored treatment program, and that no further current chemical dependency or substance abuse exists.
- t. If a PCP provider is not in full-time practice, participation will be at the sole discretion of Premier Blue.

The above criteria must be maintained on an ongoing basis by all PCPs and referral physician providers who participate with Premier Blue. The provider must notify Premier Blue within five business days if any change occurs regarding the status of Physician's hospital privileges (including restrictions), license to practice medicine (including restrictions), existence or amounts of malpractice coverage required hereunder, DEA license or Physician's involvement in an impaired physician program or

treatment for alcohol and/or substance abuse, and agrees that such may result in summary termination of this Agreement. In the event Premier Blue shall suffer any harm for failure of Physician to so notify Premier Blue, Physician agrees that Physician shall indemnify Premier Blue for all such harm caused to it. Physician agrees that any such change may result in (a) summary termination of this contract by Premier Blue if such change poses an imminent danger to Premier Blue members, or (b) termination upon notice by Premier Blue in all other circumstances. Such termination shall be effective according to its terms, and any subsequent action, such as removal of restrictions as a result of an appeal to the party initiating such changes shall not have any retroactive effect on the Physician's status hereunder.

4. The quality improvement department (QI) staff will review the credentials packet to ascertain compliance with the following credentials criteria for non-physician referral providers:
 - a. Completion of appropriate training/degree from approved school/program as required by national, state, or local requirements to obtain licensure/registration/or certification to practice profession.
 - b. Unrestricted license/registration/certification to practice profession in Kansas as required by state law.
 - c. If national, state or local regulations require a supervising provider to practice, that supervising provider must be contracting with Premier Blue.
 - d. Evidence of ongoing continuing education as evidenced by compliance with state requirements for license/registration/certification renewal.
 - e. Agreement to complete regular credentialing forms.
 - f. Agreement to participate in quality of care and utilization review programs of Premier Blue.
 - g. OSAs, as applicable, confirm that the office and medical record-keeping practices are in conformance with Premier Blue standards.
 - h. Agreement to maintain a comprehensive outpatient medical record on each Premier Blue member/patient.
 - i. Unrestricted DEA number, as appropriate, for practice.
 - j. Hospital staff membership with privileges as appropriate for practice in at least one Premier Blue contracting hospital in the community

- or an established referral process to assure access of inpatient care to members/patients based on geographic location and at the sole discretion of Premier Blue.
- k. Professional liability insurance in force that meets required amounts established by Premier Blue.
 - l. Malpractice claims history that is not suggestive of a significant quality of care problem.
 - m. Specialty appropriate coverage/timely access by provider, who has successfully completed the Premier Blue credentialing process, is arranged during absences and when unavailable on holidays, nights, weekends, and other off hours based on geographic location and at the sole discretion of Premier Blue.
 - n. Absence of patterns of behavior to suggest quality of care concerns.
 - o. Utilization review pattern consistent with peers and congruent with needs of managed care.
 - p. No sanctions placed upon him/her by Medicaid, Medicare or debarred by Federal Employee Health Benefit Program.
 - q. No disciplinary actions pending or imposed.
 - r. No felony or misdemeanor convictions to include repeated DUI or drug related arrests.
 - s. No current drug or alcohol abuse.
 - t. A referral provider is not in full-time practice; participation will be at the sole discretion of Premier Blue.

The above criteria must be maintained on an ongoing basis by all non-physician referral providers who participate with Premier Blue. The provider must notify Premier Blue within five business days if any change occurs regarding the status of referral provider's hospital privileges (including restrictions), license to practice medicine (including restrictions), existence or amounts of malpractice coverage required hereunder, DEA license or referral provider's involvement in an impaired provider program or treatment for alcohol and/or substance abuse, and agrees that such may result in summary termination of this Agreement. In the event Premier Blue shall suffer any harm for failure of referral provider to so notify Premier Blue, provider agrees that referral provider shall indemnify Premier Blue for all such harm caused to it. Referral provider agrees that any such change may result in (a) summary

termination of this contract by Premier Blue if such change poses an imminent danger to Premier Blue members, or (b) termination upon notice by Premier Blue in all other circumstances. Such termination shall be effective according to its terms, and any subsequent action, such as removal of restrictions as a result of an appeal to the party initiating such changes shall not have any retroactive effect on the referral provider's status hereunder.

5. Based upon compliance with the criteria, the QI staff will either recommend approval or disapproval to the credentials committee.
6. The credentials committee will forward a final recommendation to the Premier Blue Board of Directors.
7. The Board of Directors will grant final approval or disapproval of all providers' applications and finalizing of contracts.
8. If the Board of Directors fails to grant approval, the applicant must wait one year before re-applying for contracting status in the Primary Care Program.

B. Credentialing of Office Personnel

Providers are responsible for assuring that office personnel who claim to be licensed, certified, or registered maintain such in accordance with state law requirements.

C. Recredentialing

After a provider has completed the initial credentialing process, he/she will undergo recredentialing every three years thereafter. The recredentialing process will be conducted in the same fashion as outlined in the credentialing process.

D. Office Site Assessment (OSA)

The OSA is a risk management tool established to assess key factors in a provider's office environment. The onsite review is performed at the time of the provider's initial application.

E. Ongoing Monitoring of Sanctions and Complaints

Ongoing monthly monitoring of providers is performed in order to ensure quality and safety of care between recredentialing cycles. The monitoring is achieved via the Kansas State Board of Healing Arts (KSBHA's) Web site, the Office of Inspector General (OIG's) Web site, and review of member complaints data. When appropriate, intervention on important quality or safety issues will be referred to the credentials committee in a timely manner.

F. Provider's Rights

Provider's rights to review his/her credentialing file: A provider may request to review the information submitted in support of their credentialing application. Only the provider will be granted access, during regular business hours, on an agreed appointment time, to review his/her credentialing information in the presence of the credentialing manager/nurse coordinator.

- The practitioner will not be allowed to copy or remove any documentation from their credentialing information.
- This review will not include references or recommendations or other information that is peer review protected.

G. Erroneous/Inaccurate Information

A provider will have the opportunity to clarify information in his/her application that is inconsistent with information obtained via primary source verification during the credentialing or recredentialing process. The credentialing manager/credentialing nurse coordinator will notify the provider, in writing, of such findings and will return with the letter, a copy of the application submitted, highlighting the inconsistent information. The notice to the provider will not include copies such as information collected from the National Practitioner Data Bank, Health Care Integrity and Protection Data Bank, licensure documentation obtained from the Kansas State Board of Healing Arts, or hospital(s) queried. The provider has the right to correct erroneous information received from the verification sources directly with the verifying source. The provider will be asked to respond in writing to any conflicting information provided on the application and return a formal response to the credentialing manager within 30 days. The credentialing manager/credentialing nurse coordinator will review the information obtained against the information collected, from the primary source once again, within 30 days, to verify that there is no longer a discrepancy. The response will then be evaluated against the Premier Blue credentialing policy/procedure and requires credentialing committee review.

H. Appeals

If the determination of Premier Blue results in ineligibility, limitation of practice or provisional approval as a contracting provider, he/she will be notified of the appeal rights set forth herein. No action will be taken (other than in cases of refusing to accept the provider's initial application) until the applicant/provider exhausts his/her appeal rights or voluntarily waives the appeal rights, unless imminent risk of member's health is at stake. If this risk exists, temporary action will be implemented awaiting completion of the appeal process.

Appeal rights do not exist where there is no dispute of fact as to whether the provider satisfies all eligibility criteria or for business reasons.

Prior to institution of any legal proceedings or suit against Premier Blue, the following appeal process will be utilized by applicants/providers who disagree with the denial of, limitation of practice, or provisional approval as a contracting provider.

1. First Level of Appeal

If the applicant/provider is dissatisfied with the determination by the medical management committee of ineligibility, limitation of practice, or provisional approval as a contracting provider with Premier Blue, he/she may request the first level of the credentials appeal process. The written request should be sent to the manager of quality improvement/credentialing of Premier Blue, and must be received within 30 days of the initial determination letter. The request should outline why he/she is dissatisfied with the determination and supply additional information or highlight specific points for reconsideration.

Upon receipt of this appeal, it should be date-stamped, logged in, and referred to the manager of quality improvement/credentialing. The manager of quality improvement/credentialing will refer the request to the medical management committee. Based on the outcome of the review by the medical management committee, the manager of quality improvement/credentialing will notify the applicant of either the date when the appeal will be presented to the Premier Blue Board of Directors, or that the original decision has been modified/rescinded.

The appeal will be developed by the manager of quality improvement/credentialing to include all supportive documentation and presented to the Premier Blue Board of Directors during its next scheduled meeting. The applicant/provider will be notified within 60 days of the determination.

Upon receipt of the determination made by the Premier Blue Board, a letter shall be sent to the applicant/provider relaying the determination. If the determination of the Premier Blue Board is to grant contracting status, or allow unrestricted privileges, the application will be processed in accordance with Premier Blue's procedure. If the determination results in continued ineligibility, limitation of practice or provisional approval of contracting status, the applicant/provider will be notified of the determination and informed that he/she may request the final level of the appeal process within 30 days. The applicant/provider will also be notified of the effective date of the ineligibility, limitation of practice or provisional approval in the absence of such appeal.

2. Final Level of Appeal

If the applicant/provider chooses to request the final level of appeal,

he/she must submit a letter to the manager of quality improvement/credentialing within 30 days of the initial appeal determination. The request should outline why he/she remains dissatisfied with the determination and the applicant/provider may supply additional information or highlight points for reconsideration.

Within 30 days of receipt of the applicant's/provider's appeal, a review panel consisting of two members of the Premier Blue Board of Directors, the corporate medical director, the chair of the medical management committee, and two physicians will be appointed to review the appeal. One of the physicians will be from the same primary specialty and both will be currently participating in Premier Blue. The physicians selected will not be in direct competition with the provider. The appealing applicant/provider will be notified, in writing, at least 30 days in advance of the time, place, and date of the hearing and of any witnesses Premier Blue intends to present. The appealing applicant/provider will be informed that he/she will have the right to representation, to have a record made of the proceedings with copies available at his/her expense, to call his/her own witnesses, to present relevant evidence and to submit a written statement at the conclusion of the review.

Upon receipt of the review panel's determination a letter shall be sent to the appealing applicant/provider relaying the determination. If the determination is to grant contracting status or allow unrestricted privileges, the application will be processed in accordance with Premier Blue procedure. If the determination results in continued denial/restriction of contracting status, the applicant/provider will be notified of the determination and that this is the final decision and that all avenues of appeal have been exhausted.

If the applicant/provider remains dissatisfied with the determination, he/she may proceed with normal remedies of law, if any.

To maintain compliance with the Health Care Quality Improvement Act of 1986, professional review actions based on the provider's professional competence or professional conduct that affect his/her clinical privileges for a period of more than 30 days must be reported directly to the National Practitioner Data Bank within 15 days from the date that the determination was made. Within 15 days of receipt of this determination, the National Practitioner Data Bank will report this information to the State Board of Medical Examiners.

The Healthcare Integrity and Protection Data Bank (HIPDB) was established by HIPAA. The legislation established the HIPDB to combat fraud and abuse in health insurance and health care delivery, and to improve the quality of patient care. The HIPDB serves as a source of final adverse action information on health care practitioners, providers,

and suppliers, collecting and releasing information related to adverse licensure actions, health care related convictions and judgments, exclusions from federal and state health care programs and other adjudicated actions or decisions.

To maintain compliance with HIPAA, health plans must report certain final adverse actions taken against health care practitioners, providers, and suppliers to the HIPDB. The final adverse action must be reported directly to the HIPDB within 30 calendar days of the date the action was taken.

III. MEDICAL RECORD REVIEW

An integral component of the managed care quality improvement program is the evaluation of the health care rendered to members by contracting providers through medical record review.

The initial step in improving health care is identification of areas for improvement. Medical record documentation merits special consideration in evaluating the appropriateness and effectiveness of health care. Pertinent data collected from the medical record is analyzed according to established criteria and implicit medical knowledge by QI staff and peer reviewers. Providers are encouraged to take an active role in the review process, providing additional information and clarification when appropriate.

The second step is to work cooperatively with providers in the development of solutions to identified problems.

The third step requires that recommendations for improvement be evaluated to ensure that providers' performance meets established standards.

The final step in quality improvement through medical record review is the revisions or enhancements to recommendations that are not improving or maintaining the quality of care as planned.

Emerging patterns of confirmed inappropriate or inadequate care provided by contracting providers are monitored within the QI department. Once a problem or pattern of problems is identified, a quality improvement plan (QIP) is developed by QI staff. The QIP is implemented as an educational effort to correct a specific problem relating to the care rendered to Premier Blue members by Premier Blue contracting providers.

A QIP is developed for all providers identified as having a pattern of quality issues. Problem codes assigned to these cases are reviewed to tailor the QIP according to specified problems identified during the initial review process. Therefore, QIPs may be developed for a facility, physician, or ancillary provider depending upon the problem focus.

Evaluation of the effectiveness of the QIP will be performed at intervals appropriate to the identified problem or deficiencies, but not to exceed one (1) year.

IV. ADVERSE QUALITY OF CARE DETERMINATION AND QIP APPEAL PROCESS

An integral component of the QIP is the evaluation of health care rendered to members through medical record review.

Pertinent data is collected from the medical record and analyzed by staff according to established and implicit criteria. If quality of care concerns are identified, written or oral comments are obtained from the provider under review. All cases in which the quality of care is either questionable or substandard are referred to a physician advisor for evaluation and implementation of a QIP if necessary. If the QIP limits the provider's practice/privileges and the provider does not agree with the determination, the provider may appeal.

If as a result of an adverse quality of care determination by Premier Blue a QIP is assigned which restricts or suspends a provider's clinical privileges for greater than 30 days, or requests dismissal of a provider, the provider will be notified of the appeal rights set forth herein. No action will be taken until the provider either exhausts his/her appeals rights or voluntarily waives his/her appeal rights, unless imminent risk of member's health is at stake. If this risk is present, then a temporary action will be implemented awaiting completion of the appeals process.

Prior to the institution of any legal proceedings or suit, the appealing provider will utilize the appeal process as outlined.

The appealing provider must submit a letter to the corporate medical director within 30 days of the initial notification of the QIP requesting a direct appeal to the Premier Blue Board of Directors. The request should outline why he/she disagrees with the QIP and supply additional information or highlight specific points for reconsideration.

The provider's appeal will be developed by staff to include all supportive documentation and be presented to the Premier Blue Board of Directors during the next scheduled quarterly meeting.

Upon receipt of the outcome of the appeal from the appropriate board of directors, a letter shall be sent to the appealing provider relaying the determination. If the determination does not concur with the initial QIP, the plan will be modified or canceled and the provider so notified. If the determination results in continued upholding of the QIP the appealing provider will be notified of the decision and informed that he/she may request the final level of the appeal within 30 days. The provider will also be notified of the date the QIP will be implemented in absence of such appeal.

If the provider requests the final level of appeal, he/she must submit a letter to the vice president of medical affairs within 30 days of notification of the first level appeal determination. The request should outline why he/she continues to disagree with the QIP. The appealing provider must supply additional information or highlight specific points for

reconsideration.

Within 30 days of receipt of the provider's appeal, a review panel consisting of two members from the appropriate board of directors, the corporate medical director, vice president of medical affairs, and two physicians will be convened to review the appeal. One of the physicians will be from the same primary specialty and both will be currently participating in Premier Blue. The physicians selected will not be in direct competition with the provider. The appealing provider will be notified, in writing, at least 30 days in advance of the time, place, and date of the hearing and of any witnesses who will be present. The appealing provider will be informed that he/she will have the right to representation, to have a record made of the proceedings with copies available at his/her expense, to call his/her own witnesses, to present relevant evidence, and to submit a written statement at the conclusion of the review. Upon receipt of the review panel's decision, a letter shall be sent to the appealing provider relaying the determination. If the determination does not concur with previous decisions, the QIP will be modified or canceled. If the recommendation results in continued upholding of the QIP, the appealing provider will be notified that this is the final decision and that all avenues of appeal have been exhausted.

If the provider continues to disagree with the QIP, he/she may pursue normal remedies of law, if any.

V. HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)

Premier Blue utilizes HEDIS (Health Plan Employer Data and Information Set) to report information about its managed care products. HEDIS has been developed by the National Committee for Quality Assurance (NCQA) as a report card for employees and consumers to use to compare managed care plans to one another.

The HEDIS data set is an extensive compilation of information about a managed care plan. The data set includes sections on effectiveness of care, utilization of services, access to care, member satisfaction, and financial measures. Several of the measures, particularly in the effectiveness of care section, require a review of member's medical records to determine if a particular service, such as a mammogram or pap smear, has been provided to a member within a given time period.

These reviews are done of randomly selected members' charts in accordance with HEDIS guidelines. There are two ways that this review may occur. The chart may be reviewed by one of our nurse reviewers at the provider's office or the provider may be asked to send a copy of the patient's chart in for our review.

Due to the extensive number of charts that must be reviewed and the short timeline that the plan has to compile this information, timely response and cooperation with these medical review requests is critical. Please note that, as with all QI related medical record requests, copies of medical records for HEDIS are at the provider's expense.

VI. DISEASE MANAGEMENT (CARE MANAGEMENT)

Premier Blue has care management initiatives available for our members with diabetes, coronary artery disease, asthma, and congestive heart failure. The intent of these initiatives is to improve the overall health of our members with chronic health conditions by providing the education, tools, and one-on-one support that may assist members in having a positive impact on their health.

This HIPAA compliant program is physician directed and nurse managed via telephone. Through periodic telephone calls, the nurse case managers can assist in identifying risk factors.

Members will be contacted via phone or letter for their agreement to participate in the program. Education material is free of charge, and mailed on an individual basis.

Members will be selected for these initiatives by utilizing the health conditions risk identification tool.

VII. CLAIMS APPEAL PROCEDURE

Premier Blue follows BCBSKS claims appeal procedures as outlined in Policy Memo No.1 with the exception that the final appeal is to the Premier Blue Board of Directors.

VIII. UTILIZATION MANAGEMENT

Utilization management decisions are based on the medical appropriateness of care or service as eligible within the member's benefit structure. Premier Blue does not provide monetary compensation or financial incentives to practitioners or other consultants conducting utilization review activities that encourage underutilization of services or denials of care.

IX. STANDARDS FOR MEDICAL RECORDS

Medical records will be maintained in a manner that is current, detailed, organized and permits effective patient care and quality review in addition to complying with state requirements KAR 100•24•1. Records will reflect all aspects of patient care to include ancillary services. Records will be available to the health care provider at each encounter.

X. REFERRALS

In addition to the other policies of Premier Blue, to the extent not inconsistent with these managed care policies, the following apply:

- A. The provider agrees to use those inpatient, extended care, ancillary service and other health facilities and health professionals which have contracted with Premier Blue, including Health Management Strategies (HMS), for mental health/substance abuse services, to the extent possible. Providers agree to render services to members in the most appropriate and economical setting consistent with the member's diagnosis, treatment needs, and medical condition. Any additional costs incurred by Premier Blue as a result of a referral to non-contracting providers could be charged to the contracting provider making the referral and withheld from future payment. Premier Blue recognizes that there could be extenuating circumstances such as late night calls at home for a seriously ill patient, ambulance providers required to transport to the nearest facility, or other factors beyond the provider's control. Premier Blue would not attempt to recover any costs over and above what would have been paid to a contracting provider without first discussing the case with the provider(s) involved. Premier Blue would evaluate each case individually, taking into consideration all facts as well as past experience and recurring trends.
- B. When treating a member upon referral from a PCP or as a patient-directed standard benefit such as maternity care, well woman services, or routine eye exam, providers agree not to refer a member to another physician, health professional, or medical facility and not to admit a member to a medical facility without the prior concurrence of the referring PCP (subject to paragraph IX.A. above), except in the case of a life or limb-threatening emergency where such admittance or referral involves a circumstance where time is of the essence. The referral provider is financially responsible for all charges incurred when prior approval is not obtained.

Note: This paragraph is not applicable to the Premier Blue **Access Option** since referrals are not required for this open access program.

- C. Services provided beyond those specified by the Premier Blue referral, or those included in the maternity care, well woman services or routine eye exam become a provider write-off for the referral physician unless the referral physician obtains prior authorization from the PCP.

Note: This paragraph is not applicable to the Premier Blue **Access Option** since referrals are not required for this open access program

- D. When standard benefit services (such as maternity care, well woman services, routine eye exams) are performed, the provider must submit a written report to the member's PCP to inform them of the medical visit, test results, treatment plans, and any specialty care needs identified.

- E. If the Agreement between Premier Blue and provider is terminated for any reason, and a member:
1. is undergoing a course of continuing treatment by provider on the date of such termination;
 2. continuation of such treatment is medically necessary and in accordance with the dictates of medical prudence;
 3. the member has a special circumstance such as a disability, a life-threatening illness, or is in the third trimester of a pregnancy; and
 4. the member has requested a continuation of care by the provider through a written notice to Premier Blue and Premier Blue has authorized such continuation of care, then:
 - a. The termination of the Agreement shall not prevent the member's receipt of benefits from the provider for a period of up to 90 days from such termination; and
 - b. The provider shall continue to accept from Premier Blue for care furnished to such a member, as payment in full for covered services, subject to applicable deductibles, coinsurances, or copayments, the amounts payable by Premier Blue immediately prior to such termination.

If the Agreement with the provider includes as a part of reimbursement to the provider the participation by the provider in a risk-pool or other payment arrangement which may result in the provider receiving variable compensation based on program performance, (a) such provisions shall not apply to reimbursement hereunder for care provided after termination of the Agreement, and (b) Premier Blue shall not apply any withholds or similar reductions to payments to the provider for care provided after termination of the Agreement.

XI. APPROPRIATE PLACE OF SERVICE

It is the responsibility of the PCP or contracting referral specialist to determine the appropriate place of service, i.e., physician's office, ambulatory surgery center, or hospital outpatient department. With a valid referral, Premier Blue will reimburse the facility for a covered procedure.

XII. ELECTRONIC CLAIMS/REFERRAL OBJECTIVES

Premier Blue contracting providers recognize the importance of various electronic business systems and functions related to efficient health care administration. As such,

Premier Blue encourages the use of electronic business systems for Premier Blue contracting providers.

XIII. PHONE CONSULTATIONS

Premier Blue contracting providers recognize the importance of various electronic business systems and functions related to efficient health care administration. As such, Premier Blue encourages the use of electronic business systems for Premier Blue contracting providers.

XIV. PATIENTS/FINANCES

PCPs are asked not to discuss Premier Blue finances or other contractual issues with their patients. Any concerns, comments, or complaints surrounding finances or other matters should be directed to the professional relations representative or to the Premier Blue Medical Director.

XV. FINANCIAL REPORTS

Periodic financial reports will be provided for each PCP.

XVI. CHANGE OF STATUS

A PCP (or practice) who wishes to change his/her status must notify Premier Blue in writing sixty (60) days or more in advance of the requested date of change. Exceptions can be made to shorten the time frame due to unusual circumstances where immediate action is necessary. Enrollment applications submitted prior to the effective date of change in status will be assigned to the PCP's practice.

Established PCPs may temporarily limit their patient volume through individual consideration by Premier Blue.

XVII. PATIENT EDUCATION AND DISMISSAL- APPLICABLE TO PCPS ONLY

The Intercept Committee at Premier Blue serves as the responsible party for handling requests for member education and dismissal notifications. The objectives of the Intercept Committee are:

- Provide a forum for primary care physicians (PCPs) to request assistance with a member
- Insure members access to their benefits
- Assure members are not being dismissed due to (1) type of insurance, or (2) medical diagnoses/conditions

- A. The Intercept Committee views formal education as a valuable tool. Written education is an effective method of advising a member of specific, detailed information and placing responsibility for compliance directly on the member. The committee expects the PCP or his/her office to perform and document

verbal or written education whenever a clear set of instructions needs to be conveyed. The consequences, if there are any, for not following instructions should always be included.

Members may need to be reminded of how the managed care process works and what the role of the PCP is in the provision of managed care. Other issues requiring education may include referrals, eligible providers, etc. The Intercept Committee is available to assist PCPs with this education at their request. The PCP shall provide their professional relations representative with documentation detailing the situation: such as pertinent dates (missed appointments), documentation of conversations (verbal abuse), documentation of previous attempts to educate, and any other information that would aid the committee in clearly understanding the circumstances involved. Following receipt of the PCP's request and documentation, company staff will correspond with the member on the issue and reinforce the PCP's comments.

B. Member Dismissal

The Intercept Committee regards the dismissal of a member by the PCP as a serious matter and provides assistance when requested to support the maintenance of a solid, productive physician/patient relationship. Nonetheless, problems such as non-payment of an outstanding debt, non-compliance with the PCP's medical recommendations/office practices, or conflict/abuse toward the PCP or the PCP's staff may result in the need for member dismissal.

When a PCP dismisses a member or members from the practice, the Intercept Committee requires that a copy of the dismissal letter being sent to the member, be simultaneously sent to the attention of the Intercept Committee at cc466L1. The purpose of this is so the company can conduct timely correspondence with the member and coordinate the selection of a new PCP.

The following are important steps to follow when dismissing a Premier Blue member:

- Always send a copy of the member dismissal letter concurrently to the Intercept Committee when you notify the member.

DO include the following information in the letter:

- Premier Blue ID number
- Names of all the members being dismissed
- A statement of dismissal to the member including the specific circumstances precipitating the dismissal.
- A statement that the removal is not based on the member's medical needs or type of insurance.
- A statement indicating you or a covering provider will be available to manage the member's care until the effective date of the new PCP.

- If your office policy dictates that a member dismissed from your practice cannot choose another physician in your group, please indicate this as well.
- Indicate Premier Blue has been copied on the letter.

DO NOT include the following information in the letter:

- A specific time during which you will continue to see the member (such as 30 days).
- A statement to the member that he/she should present payment in full for services in order to be seen during the transition. You will continue to receive reimbursement from Premier Blue for covered services until the member selects a new PCP. You may collect applicable deductibles and co-insurance at the time of service.

Following the Intercept Committee 's receipt of the dismissal letter the company will:

- write the member notifying them that we have received notification of their dismissal and will advise them to select a new PCP. We will copy the PCP on this letter.
- assure the member selects a new PCP with an effective date that will be no later than the first of the month following 30 days of the Intercept Committee receipt of the PCP's dismissal letter.

If the PCP would like assistance from the Intercept Committee before proceeding with the dismissal, the PCP should contact their professional relations representative.

When a PCP accepts a previously dismissed managed care patient back into their practice, they must first notify their professional relations representative or the chair of the Intercept Committee. This allows the Intercept Committee to track and remove any PCP selection limitations, as needed. The PCP must inform the member to contact Premier Blue and select them as their PCP. Upon the member's request, the change in PCP will take effect the first of the following month.

XVIII. PROVIDER ACCESS

By provider contract, all offices shall cooperate and participate with the HMO in all of its programs relating to quality improvement to include standards of access as established by the Premier Blue Medical Management Committee.

The provider accessibility standards are:

A. Emergency Care

See member immediately or direct to nearest contracting provider (meaning care for a life-threatening condition).

B. Care Needed Right Away for an Illness or Injury

Schedule an appointment for the member within 24 hours (meaning treatment of a non-life-threatening injury or recent illness).

C. Regular or Routine Care

Schedule an appointment for the member within 14 days (meaning routine or follow-up care).

D. Preventive Care

Schedule an appointment for the member within 90 days (meaning physical exams and early detection screenings).

E. Prenatal Care

Schedule an appointment for the member within the 1st trimester (subject to member calling by 10th week of pregnancy and applicable only to providers providing obstetrical care).

F. Waiting Room Time

30 minutes-after checking in for the appointment.

G. 24-Hour Coverage

By provider contract, all offices must have 24-hour coverage. The office number, when called after hours, must provide instructions to members how to access care, i.e. roll to an answering service or answering machine.

Compliance with accessibility standards is monitored annually through complaint and appeal trends and an after hours accessibility audit.

XIX. MEMBER COMPLAINT AND GRIEVANCE PROCEDURE

Premier Blue recognizes that from time to time members may encounter situations where the performance of the HMO or their PCP does not meet their expectations. When this occurs, the member has the right to direct an inquiry to Premier Blue. A non-claim inquiry may be received by telephone, in writing, or in person. A claim inquiry (appeal) must be in writing. It is the policy of Premier Blue to promptly and fairly consider all inquiries of its members.

Complaints are reviewed on an on going basis. The member's PCP may be contacted by their professional relations representative for additional information, such as medical records, to assist in resolving the matter. Following receipt of all the necessary

information, a thorough review is conducted and a determination made. When the outcome of the case affects the PCP, a representative will contact the PCP to apprise them of the determination.

Premier Blue monitors the number and type of complaints made by members, and monitors trends and patterns.

If a member requests information on filing an inquiry, they should be forwarded to their respective customer service areas:

Premier Blue Member Services
P.O. Box 239
Topeka, Kansas 66629
(785) 291-4010
1-800-332-0028

XX. GRIEVANCE COMMITTEE COMPOSITION

The PCP agrees to serve on an ad hoc grievance committee as called upon by the Medical Director with reasonable notification and time commitment.

XXI. PATIENT WAIVER

If a physician disagrees with the HMO's medical necessity determination using their best medical judgment, the physician may provide the service if the patient understands in advance that the HMO will not pay for the service and the patient is financially responsible and a waiver should be completed in advance.

XXII. PREMIER BLUE ACCESS OPTION (open access product)

Access Option has no PCP referral requirements. Members receive the highest level of benefits when services are received from a contracting Premier Blue provider. Members are encouraged to select a PCP.

Existing Premier Blue fee schedules and withholds are applicable to **Access Option**. Reimbursement is fee for service for all services (there is no PCP capitation for **Access Option**).

XXIII. MEMBER'S RIGHTS AND RESPONSIBILITIES

The following is the Member Rights & Responsibilities document provided to members and providers. The document seeks to convey to members their rights and responsibilities when seeking health care and service.

It is the responsibility of Premier Blue and its contracting providers to treat you and/or members of your family in a manner that acknowledges and supports your basic human rights. Premier Blue assumes the role of resolving organizational problems that interfere

with exercising your stated rights and responsibilities. The extent to which these rights and responsibilities are enforceable by the member or Premier Blue is governed solely by the Premier Blue contract. These rights and responsibilities are detailed below:

- A. You have the right to considerate and courteous care, with respect for personal privacy and dignity.
- B. You have the responsibility to treat all Premier Blue personnel respectfully and courteously as partners in good health care.
- C. You have the right to select your own personal PCP from the list of contracting PCPs of Premier Blue. However, if your first selection is not satisfactory, you have the right to choose a different PCP.
- D. You have the responsibility to select a PCP and to communicate openly with that PCP. You have the responsibility to develop a physician-patient relationship based on trust and cooperation. You are expected to coordinate all your care with your PCP. This continuity strengthens the positive relationship between you and your physician and enables your PCP to develop a better understanding of your needs.
- E. You have the right to expect your PCP's health care team to provide or arrange for all medically necessary care, except for care not requiring PCP authorization.
- F. You have the responsibility to seek and obtain referrals from your PCP for services received only from Premier Blue contracting professionals. Exceptions apply only to medical emergencies or the initial treatment of accidental injury or illness.
- G. You have the right to participate in the health care process with the professionals who can help you take charge of your health.
- H. You have the primary responsibility to maintain your health and prevent illness. By using the information Premier Blue provides, and by making positive health choices and seeking appropriate care when it is needed, you will be taking charge of your health.
- I. You have the right to receive enough information to enable you to make a thoughtful decision before you receive any recommended treatment.
- J. You have the responsibility to ask questions and make certain that you understand the explanations and instructions you are given.
- K. You have the right to refuse to participate in experimental research.
- L. You have the responsibility to advise your PCP and/or Premier Blue when an experimental treatment is being recommended against your wishes.

- M. You have the right to be informed of your diagnosis and treatment plan in terms that you understand and to participate in decisions involving your medical care.
- N. You have the responsibility to consider the potential consequences if you refuse to comply with treatment plans or recommendations.
- O. You have the right to reasonable access to appropriate medical services.
- P. You have the responsibility to keep scheduled appointments or to give adequate notice of delay or cancellation and to notify Premier Blue if you are unable to access appropriate medical services.
- Q. You have the right to a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. You have the right to receive the benefits of your Premier Blue membership and to be informed of available services, as well as where, when, and how you can obtain these services.
- R. You have the responsibility to read all Premier Blue materials carefully and immediately upon your enrollment and to ask questions when necessary. You have the responsibility to follow the rules for your Premier Blue membership.
- S. You have the right to receive assistance when language barriers exist between you or a member of your family and a provider of approved services.
- T. You have the responsibility to advise your PCP and/or Premier Blue when you require assistance, to allow for adequate communication between you or your family member and a provider. Premier Blue will assist in making the appropriate arrangements.
- U. You have the right for your health records to be kept confidential except when disclosure is required by law or by Premier Blue. With adequate notice, you have the right to review your medical record with your PCP.
- V. You have the responsibility to help maintain accurate and current medical records by being honest and complete when providing information to health care professionals.
- W. You have the right to express a complaint and to receive an answer to the complaint within a reasonable period of time.
- X. You have the responsibility to express your opinions, concerns, or complaints in a constructive manner to the appropriate people at Premier Blue.

XXIV. MEMBER SATISFACTION SURVEY

Members' perceptions are an essential source of information for Premier Blue. A satisfaction survey is not only a good management tool, but also a key indicator of the quality of care being provided.

Premier Blue contracts with an NCQA certified independent survey firm to conduct the CAHPS 3.0H survey (Consumer Assessment of Health Plans Study). This tool is a standardized survey utilized to gain Premier Blue members' responses about their levels of satisfaction. The mail-out survey is sent to active members. The survey contains sections of: "Your Personal Doctor or Nurse," "Getting Health Care from a Specialist," "Your Health Care in the Last 12 Months," "Your Health Plan" and "About You."

Premier Blue is committed to continuous quality improvement and survey results are analyzed to determine areas of strength and areas of concern. Root causes are identified and action plans implemented so improvements can be achieved.

XXV. PROVIDER SATISFACTION

Providers' perceptions are an essential source of information for BCBSKS. A provider satisfaction survey is not only a good management tool, but also a key indicator of the quality of care and service being provided. Surveys may be developed to monitor satisfaction of providers. Feedback received provides an opportunity to implement process improvements aimed at achieving high-quality care, service, and retention of providers.