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 policies and procedures (#1-3 and 5-12, Ambulance, Home Medical Equipment and Dental) contractual obligations. These guidelines have been approved by the Premier Blue Board of Directors.

I. 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 staff will review the credentials packet to ascertain compliance with the following credentials criteria:

   a. D.O. or M.D. degree; graduation from a 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. In order to participate in Premier Blue, a provider must participate in the Competitive Allowance Program (CAP) of Blue Cross and Blue Shield of Kansas.

   b. Current and unrestricted license to practice medicine in Kansas.

   c. Evidence of ongoing continuing medical education as evidenced by compliance with State requirements for license renewal.

   d. Primary care physicians 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.

I. CREDENTIALING (continued)

A. Credentialing (continued)

e. Referral physician providers must supply documentation of successful completion of postgraduate training that satisfies requirements of the appropriate specialty board.

f. Agreement to complete regular credentialing forms.

g. Agreement to participate in quality of care and utilization review programs of Premier Blue.

h. Office Site Assessment confirms that the office and medical record keeping practices are in conformance with Premier Blue standards.

i. Agreement to maintain a comprehensive medical record on each Premier Blue member/patient.

j. Current and unrestricted DEA number as appropriate for practice.

k. Hospital staff membership with admitting privileges in at least one Premier Blue contracting hospital in the community in which the PCP's medical office is located or an established referral process to assure access of inpatient care to member/patient based on geographic location and at the sole discretion of Premier Blue.

l. Provider must live within a reasonable distance of their practice to assure availability for urgent care within an appropriate time period as determined by the Credentials Committee.

m. Hospital section/staff membership privileges consistent with declared primary specialty.

n. Professional liability insurance in force that meets required amounts as established by Premier Blue.

o. Malpractice claims history that is not suggestive of a significant quality of care problem.

p. Specialty appropriate coverage/timely access by a Premier Blue participating provider is arranged, by the primary care physician, 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.

q. Specialty appropriate coverage/timely access by a provider, who has successfully completed the Premier Blue Credentialing process, is arranged by the referral physician provider 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.

r. Absence of patterns of behavior to suggest quality of care concerns.

s. Utilization review pattern consistent with peers in designated primary specialty and congruent with needs of managed care.

t. No sanctions placed upon him/her by Medicaid, Medicare or disbarred by Federal Employee Health Benefit Program.

u. No disciplinary actions pending or imposed.

v. No felony or misdemeanor convictions to include repeated DUI or drug related arrests.

I. CREDENTIALING (continued)

A. Credentialing (continued)

w. No current drug or alcohol abuse.

x. If a primary care physician is not in full-time practice, participation will be at the sole discretion of Premier Blue.

The above criteria must be maintained on an on-going basis by all 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 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. Office Site Assessment, as applicable, confirms 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.

I. CREDENTIALING (continued)

A. Credentialing (continued)

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 disbarred 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. If 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 on-going 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 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.

5. Based upon compliance with the criteria, the Quality Improvement 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.

I. CREDENTIALING (continued)

A. Credentialing (continued)

8. If the Board of Directors fail 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 two years thereafter.

The recredentialing process will be conducted in the same fashion as outlined in the credentialing process.

D. Office Site Assessment (OSA)

The office site assessment (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 and at a minimum of every two years thereafter dependent upon the provider specialty and member volume.

E. 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. A provider may be granted access, during regular business hours, on an agreed appointment time, to review their 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.

Erroneous/inaccurate information: A provider will have the opportunity to clarify information in their application that is inconsistent with information obtained via primary source verification during the credentialing or recredentialing process. The Credentialing Manager/Nurse Coordinator will notify the practitioner/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 practitioner will not include copies of such information collected from the National Practitioner DataBank, license documentation obtained from the Licensing Board or hospital queried. The practitioner/provider has the right to correct erroneous information received from verification sources directly with the verifying source. The practitioner/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/Nurse Coordinator within 30 days. The Credentialing Manager/Nurse Coordinator will review the information obtained against the information collected from the primary source once again to verify that there is no longer a discrepancy, within 30 days. The responses will then be evaluated against the Premier Blue Credentialing Standards and require Credential Committee review.

I. CREDENTIALING (continued)

F . 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, 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, Quality Improvement/Credentialing. The Manager, 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, 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, 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 the ineligibility, limitation of practice or provisional approval in the absence of such appeal.

I. CREDENTIALING (continued)

F. Appeals (continued)

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, 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.

II. RETROSPECTIVE MEDICAL REVIEW

An integral component of the Managed Care Quality Improvement Plan 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 quality improvement staff. 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.

II. RETROSPECTIVE MEDICAL REVIEW (continued)

The final step in quality improvement through medical record review is the revisions or enhancements to recommendations which 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 quality improvement 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 severity rankings. Problem codes assigned to these cases are reviewed to tailor the QIP according to specified problems identified during the initial review process. Therefore, QIP's may be developed for a facility, physician, or ancillary provider depending upon the problem focus.

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

III. OFFICE MEDICAL RECORD REVIEWS

The office medical record is an important clinical management tool and essential component of the Managed Care Quality Improvement Program. Office record reviews (ORRs) are performed regularly to assure that members are receiving appropriate early detection health care in accordance with review criteria as established by managed care providers and quality improvement staff.

The medical record begins with a complete medical and psychosocial history to include health related behaviors, special needs, and exposure to health risks. Routine physical examinations, preventive health care, and counseling are tailored to the individual according to personal and family history, age, gender and current health status.

To assure and continuously improve the quality of care provided in the outpatient setting, skilled clinical reviewers perform thorough and systematic reviews of the provider's medical records. These reviewers provide education to health care professionals based on the evaluation of the quality of health care provided, as can be seen in the medical record.

Current national guidelines are the Office Record Review Program's foundation. The quality indicators used to conduct the office record review were researched and developed by the Premier Blue Quality Improvement Committees, consisting of managed care providers and quality improvement staff and approved by the Premier Blue Medical Management Committee. Review of the ORR quality indicators are performed annually in conjunction with the Premier Blue Reference Guide for Preventive Medicine. (Attachment A)

Primary care physicians (PCPs) with 75 or greater managed care members undergo an ORR annually.

Additional ORRs may be performed at the request of the Medical Management Committee. These reviews may be limited or modified and are reported to the Credentials Committee.

The office medical records are randomly selected from members who have had at least one encounter with their PCP. The medical records are reviewed based on (but not limited to) Preventive Health and Diagnosis specific categories of criteria. Member records are reviewed within specific categories as applicable and within the confines of the provider and member effective dates.

Up to 6 charts are reviewed per category dependent upon the provider's medical practice and patient population. A target score of 80% is encouraged for each quality indicator. Target scores (%) will be determined and a 95% confidence interval will be calculated for each of the indicators. This will take into account the "score" on that indicator, the size of the sample and the size of the applicable population. An indicator will be considered to be "passing" if the upper limit of the confidence interval

III. OFFICE MEDICAL RECORD REVIEWS (continued)

meets or exceeds 80%. The exceptions to this are: 1) 100% of the possible charts are reviewed within a given category there is no confidence interval, 2) when a score of 0% or 100% is achieved on an indicator, or 3) any indicator which is designated "n/s", or cannot be scored due to an insufficient number of records, less than five, applicable to the quality indicator.

Arrangements for ORRs are made in advance with provider office staff by quality improvement staff. Once a date and time for the review is established, quality improvement staff will forward a confirmation letter with a list of members whose records have been selected for review to the providers office.

An exit interview to discuss pertinent findings identified during the review process follows each review. Physicians and their staff are encouraged to attend. The Medical Review Coordinator, (MRC) will discuss pertinent strengths and weaknesses identified during the review process. Any discrepancies between the findings of the MRC and the actual documentation or process is discussed at the exit interview. A review result letter and detailed reports of the review are provided at the time of the exit interview.

All quality indicators with a score less than 80% are below the targeted score and reported to the Premier Blue Medical Management Committee for further action as appropriate.

IV. HEALTH PLAN EMPLOYEE DATA AND INFORMATION SET (HEDIS)

Blue Cross and Blue Shield of Kansas utilizes HEDIS (Health Plan Employee 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. None of the charts which are reviewed strictly as part of the HEDIS data collection will affect provider scores on Office Record Review (as described in section II. A.). Please note that, as with all QI-related medical record requests, copies of medical records for HEDIS are at the provider's expense.

V. CLAIMS APPEAL PROCEDURE

The contracting provider shall have the right of appeal on a claim adjudication or medical necessity determination for covered services, whether denied in whole or in part and communicated to the member. Before entering into the appeals process, the contracting provider should verify the original payment determination through established inquiry procedures. The inquiry to verify the original payment determination must be made within 90 days of payment.

A. Written notification of disagreement highlighting specific points for reconsideration of a claim adjudication or medical necessity determination shall be provided to Premier Blue, within 90 days of receipt of payment verification. This notice shall be considered an initial appeal and be forwarded with all pertinent medical records to the Medical Director of Premier Blue. Medical

V. CLAIMS APPEAL PROCEDURE (continued)

records submitted with the request for initial appeal will be referred to the appropriate consultant and a determination will be rendered. This decision will be binding unless the provider re-appeals the decision within 90 days of notification.

B. A final appeal may be initiated by forwarding a written request to the Medical Director of Premier Blue The final appeal determination shall be rendered by a committee as designated by the Premier Blue Board of Directors. The contracting provider contractually agrees to abide by the final determination in the appeals process.

All appeals decisions made by Premier Blue must be rendered within 90 days of receipt of the provider's request. Any appeals decision not rendered within the aforementioned time frames shall be considered as decisions made in favor of the provider and claim payments will be adjusted accordingly.

Cases may only be appealed once at each step in levels A and B above. A contracting provider agrees to accept the determination made at each level or to appeal the claim at the next step of the appeals process. If throughout the appeals process the decision on the claim changes in the provider's favor, an additional payment will be made. If, however, the decision reverses a previous determination (either partially or totally), a refund will be requested. The result of the appeals process shall be binding on the provider and Premier Blue, and each party recognizes that litigation before or after the appeals process constitutes a breach of the contract.

VI. 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.

VII. 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 and the criteria as outlined in exhibit 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.

VIII. 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.

VIII. REFERRALS (continued)

B. When treating a Member upon referral from a Primary Care Physician 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 Primary Care Physician (subject to paragraph VI.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 Primary Care Physician.

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.

IX. APPROPRIATE PLACE OF SERVICE

It is the responsibility of the primary care physician 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. ASCs will be reimbursed their charges up to a maximum allowable payment (MAP) and hospital outpatient departments will be reimbursed their charges up to a MAP of the charges less the discount established by Blue Cross and Blue Shield of Kansas reimbursement policies, whichever is applicable.

X. ELECTRONIC CLAIMS/REFERRAL OBJECTIVES

Premier Blue contracting providers recognize the importance of electronic (paperless) systems related to health care delivery capabilities. As such, it is necessary to utilize the PICS network for claims filing, timely referrals and precertification within six months from becoming a Premier Blue contracting provider.

XI. PHONE CONSULTATIONS

Phone consultations provided by the Primary Care Physician or referral provider to patients with Premier Blue coverage are considered an integral part of managed care services and as such are not billed to the patient.

XII. PATIENT FINANCES

Primary Care Physicians 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.

XIII. FINANCIAL REPORTS

Periodic financial reports will be provided for each primary care physician.

XIV. CHANGE OF STATUS

A Primary Care Physician (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 Primary Care Physician's practice.

Established Primary Care Physicians may temporarily limit their patient volume through individual consideration by Premier Blue.

XV. PATIENT EDUCATION AND DISMISSAL

It is the endeavor of the Primary Care Programs at Blue Cross and Blue Shield of Kansas to assist Primary Care Physicians in their role as providers to Premier Blue members. On occasion, a PCP may request assistance with a particular member. The Intercept Committee at Blue Cross and Blue Shield serves as the responsible party for reviewing all requests that are identified by the PCP or Plan staff. Requests must be directed to the PCP's Professional Relations Representative with supporting documentation about the situation. The committee reviews cases and makes determinations weekly. Occasionally, additional information is needed from the PCP's office and other parties in order for a thorough review to take place. It is the goal of the Intercept Committee to make a determination on a case within 30 days. The committee reviews types and number of cases monthly to determine if there are trends. This data is analyzed to determine areas of strength and areas of concern. Root causes are identified and action plans implemented so improvements can be made.

XV. PATIENT EDUCATION AND DISMISSAL (continued)

The following is an attempt to clarify what types of cases the Intercept Committee reviews, what information the committee needs, and what the PCP can expect from the review process.

A. Member Education

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 encourages offices to conduct written education whenever a clear set of instructions need to be conveyed. The consequences, if there are any, for not following instructions should always be included.

On occasion, the PCP may desire follow-up education by Premier Blue. 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 benefits, referrals, eligible providers, etc. Backup documentation should include details of the situation, such as pertinent dates (missed appointments), documentation of conversations (verbal abuse), documentation of previous attempts to educate**,** and any information that would aid the committee in clearly understanding the circumstances involved. NOTE: It is the expectation of the committee that the PCP or his/her office will have performed and documented verbal or written education with the member before asking for assistance.

When a request for education has been approved, the PCP will be advised by the Professional Relations Representative to forward an education letter to the member, if one has not been sent recently. Following receipt of the PCP's education letter, Plan staff will send an education letter to the member reinforcing the PCP's comments.

B. Member Dismissal

It is the policy of the Intercept Committee to regard the request for dismissal of a member by the PCP as a serious matter. Assistance is given to members and physicians in order to support the maintenance of a solid productive patient/physician relationship. Frequent problems causing PCP's to request dismissal of a member are: 1) nonpayment of an outstanding debt; 2) noncompliance with the PCP's medical recommendations, or office practices (missed appointments, referral requests, etc.); and 3) interpersonal conflict between the PCP/office staff and the member. In such cases, back-up documentation should include pertinent information based on the type of problem. Primary care physicians may <u>not</u> request the removal of a patient because of anticipated high medical costs, high utilization, or type of insurance.

All requests for member dismissal must be directed to the PCP’s Professional Relations Representative and reviewed by the Intercept Committee before dismissal can be implemented. Do not send dismissal letters to members before the Committee has reviewed the case. This may result in confusion to the member as another dismissal letter may be requested by the Committee so the date of the PCP’s letter coincides with the Plan’s dismissal correspondence.

Requests must be approved by the PCP. PCP approval can be communicated by signature of the PCP on the dismissal request, by documented approval in the dismissal request, i.e. "Dr. Jones has been advised and approves the dismissal request", or by a one time letter which states that the PCP has authorized a staff member to act on his/her behalf. PCP approval can also be communicated by hand signature of the PCP on the dismissal letter to the member, without documentation of approval in the dismissal request, if this is customarily the practice of the physician to do so. All dismissal requests by office staff need to be signed.

Requests for dismissal due to unpaid debts will require review of the billing statement and letters that have advised the patient to pay their bill. Requests for dismissal for noncompliance with medical recommendations requires the review of medical records by the Corporate Medical Director. The medical records should demonstrate what the PCP's recommendations have been, how long the noncompliance has existed, what the patient has been doing that constitutes the

XV. PATIENT EDUCATION AND DISMISSAL (continued)

B. Member Dismissal (continued)

noncompliance and attempts made to educate the member on consequences of continued non-compliance. Requests for dismissal due to non-compliance with office practices require the review of documentation discussing the problem, to include attempts made to educate the member. Requests for dismissal due to conflict or abuse requires the review of documentation showing what the office staff and/or PCP has experienced and tried to do to rectify the problem. Any additional information that will aid in the committee clearly understanding the circumstances involved in the situation should be forwarded for review.

When a request for dismissal has been approved, the PCP will receive a form letter which will advise them on how to proceed to dismiss the member from his/her practice as well as when the effective date of the dismissal will be (first of the month following 30 days after the Plan receives the PCP's dismissal letter). Upon the committee's receipt of the PCP's dismissal letter to the member, the committee will write the member advising him/her of the need to select a new PCP by the specified date. Enclosed with the dismissal letter is a Records Release form. This form allows the member to readily proceed with transfer of records from the old PCP to the new PCP. The PCP continues to be responsible for providing or referring for care until the member's effective date with a new PCP.

The previous sections discuss the most frequently seen cases, however the Intercept Committee will review any case the PCP feels requires the committee's review. In the event that the case does not require committee review, the Professional Relations Representative will give direction to the PCP on how to resolve the PCP's concerns.

Any questions regarding the Intercept process should be directed to the PCP's Blue Cross and Blue Shield Professional Relations Representative.

XVI. 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:

Emergency Care – See member immediately or direct to nearest contracting provider.
-meaning care for a life-threatening condition

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

Regular or Routine Care – Schedule an appointment for the member within 14 days.
-meaning routine or follow-up care

Preventive Care – Schedule an appointment for the member within 90 days.
-meaning physical exams and early detection screenings

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

Waiting Room Time – 30 minutes
-after checking in for the appointment

XVI. PROVIDER ACCESS (continued)

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 Office Site Assessment, Complaint and Grievance trends, and an After Hour Study.

XVII. 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. An inquiry may be received by telephone, in writing, or in person. 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 Primary Care Physician 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. If a member remains dissatisfied, he/she may request a formal grievance hearing to which the PCP may be asked to attend.

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 C-3518
Topeka, Kansas 66601-3518
(785) 291-4010
1-800-332-0028

XVIII. GRIEVANCE COMMITTEE COMPOSITION

The Primary Care Physicians agree to serve on an ad hoc grievance committee as called upon by the Medical Director with reasonable notification and time commitment.

XIX. 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.

XX. 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 primary care physician.

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

XXI. 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:

* You have the right to considerate and courteous care, with respect for personal privacy and dignity.

  You have the responsibility to treat all Premier Blue personnel respectfully and courteously as partners in good health care.

* You have the right to select your own personal Primary Care Physician (PCP) from the list of contracting PCP's of Premier Blue. However, if your first selection is not satisfactory, you have the right to choose a different PCP.

  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.

* 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.

  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 .

* You have the right to participate in the health care process with the professionals who can help you take charge of your health.

  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.

* You have the right to receive enough information to enable you to make a thoughtful decision before you receive any recommended treatment.

  You have the responsibility to ask questions and make certain that you understand the explanations and instructions you are given.

* You have the right to refuse to participate in experimental research.

  You have the responsibility to advise your PCP and/or Premier Blue when an experimental treatment is being recommended against your wishes.

XXI. MEMBER'S RIGHTS AND RESPONSIBILITIES (continued)

* 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.

  You have the responsibility to consider the potential consequences if you refuse to comply with treatment plans or recommendations.

* You have the right to reasonable access to appropriate medical services.

  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.

* 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.

  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.

* 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.

  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.

* 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.

  You have the responsibility to help maintain accurate and current medical records by being honest and complete when providing information to health care professionals.

* You have the right to express a complaint and to receive an answer to the complaint within a reasonable period of time.

  You have the responsibility to express your opinions, concerns, or complaints in a constructive manner to the appropriate people at Premier Blue.

XXII. MEMBER SATISFACTION SURVEY

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

Premier Blue contracts with Intelliscan, Inc., an independent survey firm from Bridgeport, Pennsylvania, to conduct the CAHPS 2.0H 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. Follow-up telephone contacts are made to non-respondents. The survey contains sections of: "Your Personal Doctor or Nurse," "Getting Health Care from a Specialist," "Calling Doctors' Offices," "Your Health Care in the Last 12 Months," Your Health Plan" and "About You."

XXII. MEMBER SATISFACTION SURVEY (continued)

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.

XXIII. PROVIDER SATISFACTION

Providers' perceptions are an essential source of information for the managed care plan. Surveys, developed to monitor satisfaction of primary care physicians and referral specialists with the managed care plan, provide an opportunity to implement process improvements aimed at achieving high quality care and service and retention of providers. The survey data is used in conjunction with the other components of the Quality Improvement program, but can also be used as a stand-alone tool. A provider satisfaction survey is not only a good management tool, but a key indicator of the quality of care and service being provided.

Surveys are sent to current contracting primary care physicians and referral specialists with the managed care plan at the time of the survey.

The survey tool is designed to gain an estimation of the level of satisfaction of providers with a wide range of experiences with the managed care plan. The survey tool is also designed to gain an estimation of the level of comparison between the managed care plan and other managed care plans with whom the provider contracts. The survey tools for the primary care physicians and referral specialists were similar, yet not identical. The parentheses below denote if questions are asked of primary care physicians, referral specialists or both.

The survey tool covers the following broad range topics:

- Experience with the plan (PCP/RS)
- Amount of input into decision making in the plan (PCP)
- Plan's education of members on benefits and coverage (PCP/RS)
- Quality of hospitals (PCP/RS)
- Level of support provided by professional relations representative (PCP/RS)
- Referral process (PCP/RS)
- Quality of specialists (PCP)
- Communication between providers (PCP/RS)
- Incentive system (PCP/RS)
- Utilization management (PCP/RS)
- Approval of services (PCP/RS)
- Case management (PCP/RS)
- Provider appeals process (PCP/RS)
- Plan's mental health vendor (PCP/RS)
- Degree to which expectations were met as presented when contract began (PCP/RS)

The managed care plan is committed to continuous quality improvement for its organization. Following receipt of the survey responses, the results are shared with a number of cross-functional teams i.e. Medical Management Committee and Network Management Committee who carry responsibility for analysis, developing action plans and recommendations for implementation. The results are then shared with the provider network via physician newsletters i.e. FYI.

Provider Satisfaction Surveys are conducted annually.