



Provider Manual

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Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

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Purpose and Introduction

Empire BlueCross BlueShield (“Empire”) is committed to helping you with hassle-free healthcare administration by providing you with the information you need, when you need it. This easy-to-use resource contains quick reference guides, information on Empire’s plans, networks, administrative procedures and medical management policies. Our manual has been updated and restructured with you in mind—to make it easier for you to do business with us.

We strive to partner with our participating physicians and other participating healthcare providers to promote healthcare quality, access and affordability. We thank you for your participation in our network and for the care you provide, every day, to our members and your patients. We look forward to continuing to work with you in our efforts to simplify the connection between healthcare and value.

This Manual is intended to support all entities and individuals that have contracted with Empire. The use of “Provider” within this manual refers to entities and individuals contracted with Empire that bill on a CMS 1500. They may also be referred to as Professional Providers in some instances. The use of “Facility” within this manual refers to entities contracted with Empire that bill on a UB 04, such as Acute General Hospitals and Ambulatory Surgery Centers. General references to “Provider Inquiry”, “Provider Website”, “Provider Network Manager” and similar terms apply to both Providers and Facilities.

Empire is redesigning the provider public website to make it easier and more useful for Providers and Facilities. Empire is working hard to move resources into the new redesigned website for an enhanced Provider experience. In the meantime, Providers and Facilities can still access most of our resources on our legacy site. It is possible that links or navigation instructions within this Manual may not work during this transition time. Empire will work to minimize any disruption during this time.

Information Sources

Empire’s website: empireblue.com/provider

- Behavioral Health Management
- BlueCard
- [Download Commonly Used Forms and Quick Guides](#)
- Electronic Data Interchange (EDI)
- Health Product Chart

- MediBlue/Medicare Advantage
- Newsletters (Access past and current issues)
- Pharmacy Management
- Physician Office Lab (POL)List
- Practice Guidelines
- Provider Manual
- Quality Improvements and Standards
- Site of Service Listing

Empire's Newsletter

Our provider newsletter is our primary source for providing important information to Providers and Facilities. The newsletter is available monthly on providernews.empireblue.com and via email distribution. You can easily locate the newsletter online by visiting empireblue.com/provider/ Select [Read the Most Recent Provider News.](#)

Legal and Administrative Requirements Overview

Empire is an independent licensee of the Blue Cross and Blue Shield Association. We maintain a network of independent physicians, multi-specialty group practices, ancillary providers and health care facilities contracted to provide health care services to our members.

Below is a glossary of terms for the Empire Provider Manual ("Manual"). For better readability within the Manual, we do not capitalize many of the terms defined in the glossary section that are capitalized in your Agreement. Please note this does not change the meaning of those terms for the purposes of your Agreement.

Covered Services means Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Covered Member is eligible for coverage. Covered Services do not include the preventable adverse events set forth in this provider manual.

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

Health Benefit Plan means the document(s) describing the partially or wholly: 1) insured, 2) underwritten, and/or 3) administered, marketed health care benefits, or services program between the Plan and an employer, governmental entity, or other entity or individual.

Network/Participating Provider means a provider designated by Plan to participate in one or more Network(s)

Please note: Material in this Manual is subject to change. The most up-to-date version is available online at empireblue.com.

Addition of New Providers to a Provider Group Agreement

Providers operating under an existing participation agreement, (individual or group) with Empire are required to notify Empire of any new providers joining or leaving the practice at least forty five (45) days in advance.

No provider subsequently joining a practice shall be authorized to render services to members as a participating

provider, until the practice has been notified in writing that Empire or its designee has completed its credentialing review and system upload of such provider and approved his or her participation under the executed participation agreement. In the event that the provider or practice submits claims for new providers prior to Empire completing its credentialing reviews, the provider or practice will hold Empire and member harmless for the charges.

Advance Patient Notice for Use of a Non-Participating Provider

Consistent with the terms of your participating agreement, you are required to refer to participating facilities, physicians, or practitioners. It is important that our members be made fully aware of the financial implications when they are referred by their physician, on a non-urgent basis, to a non-participating provider. It is especially critical to notify our members when using a non-participating provider in their provider's own office for services such as laboratory, anesthesia, specialty drugs, infusion therapy or durable medical equipment. Likewise, members should be made aware if their selected participating surgeon has chosen to use a non-participating assistant surgeon or ambulatory surgery center in a scheduled surgery. In both of these cases, the member has no way of knowing that a non-participating provider was involved in their care unless informed, in advance, by their physician. While certain members may have out-of network benefits, it is very disconcerting to them when they are presented with unexpected financial obligations for out of network medical services. We hope you agree.

In our effort to assist you in ensuring that your patients are active participants in the decision to use a non-participating provider in the situations described, Empire has adopted a policy regarding disclosure to our members when a participating provider involves a non-participating provider in their patient's care - "[Use of a Non-Participating Provider Advance Patient Notice Policy](#)". This policy is intended to ensure that patients receive prior notification of the use of a non-participating provider when the provision of those services is within the control of the physician or other healthcare provider and the patient, in the absence of this notice, is unlikely to be aware that he/she will be receiving care from a non-participating provider until they receive a bill for the services rendered.

This policy is not intended to deter patients from using their out-of-network coverage to the extent available. To the contrary, this policy is designed to ensure that, in non-emergent situations, when our members receive services from a non-participating provider it is because they were involved in the decision making process and made a conscious election. Therefore, we have developed an Advance Patient Notice (APN) to be used when you deem it necessary to refer out of network for these services. This APN basically provides the patient with the information he or she would need to make an informed decision about coverage and options. We expect that you will provide the patient with this form before involving a non-participating provider in your patient's care in the situations noted and maintain it in your files for future verification and/or audit.

Please note that this policy does not apply to emergent situations. Likewise, this policy does not apply when you or the member have obtained Empire's prior approval for the referral. When you or your patient has contacted us and received approval in advance to proceed with an out-of network service in your office or use a non-participating surgical assistant in a scheduled surgery, you may do so, without use of the APN form. As always, Empire will grant approval for the use of non-participating facilities, physicians, or practitioners on an in network basis as provided in our network exception policies (such as when no in network facility, surgeon or practitioners practicing within an appropriate surgical specialty is available to assist in a surgery requiring a surgical assistant) and as provided or required under applicable law. Of course, we believe that we have a large enough network to accommodate the needs of your patients through participating physicians and facilities and ask that you contact us if you feel this is not so.

This prior notification must be in the form of the [APN form](#) for the following non-participating services:

- In Office Anesthesiologist (i.e., anesthesia for in-office surgeries or anesthesia provided in connection with surgery or services performed at a free standing surgical center owned in whole or in part by the referring physician)

- Surgical Assistant (regardless of surgical setting)
- Specialty Drug vendor for specialty drugs provided in the office
- In Office Home Infusion Therapy (HIT)
- In Office Durable Medical Equipment
- Laboratory services for specimens collected in the physician's office when the specimen is sent to a non-participating reference lab
- Ambulatory Surgical Centers (this excludes Hospital Out-patient Ambulatory Surgical Departments)
- Endoscopy Centers
- Office Based Surgical Suites

Example: A participating gastroenterologist is scheduling an endoscopy and plans to use a non-participating anesthesiologist or assistant surgeon. The patient must be presented with the APN form at the time the procedure is scheduled unless the physician or the patient obtained Empire's approval.

Example: A participating gastroenterologist is scheduling an endoscopy and plans to use a non-participating Ambulatory Surgical Center or Endoscopy center. The patient must be presented with the APN form at the time the procedure is scheduled unless the physician or the patient obtained Empire's approval

Example: A provider collects a lab specimen in the provider's office but plans to send specimens to a lab other than Quest Diagnostics, LabCorp of America or another participating laboratory. The patient must be presented with the APN form at the time the procedure is scheduled unless the physician or the patient obtained Empire's approval.

Example: A participating Primary Care Physician refers to a non-participating specialist and the physician or member has obtained authorization. The use of the APN form is NOT required.

Example: A participating orthopedic surgeon refers a member to a non-participating neurosurgeon for a future consult in the neurosurgeon's separate office. The use of the APN form is NOT required.

Example: A physician schedules a procedure at a non-participating surgical suite that is billed as a non-participating facility. The patient must be presented with the APN form before the procedure is scheduled unless the physician or the patient obtained Empire's prior approval.

As noted above, once completed, a copy of the signed form should be kept on file to be provided to Empire upon request. Although the use of the APN form will not be required under some circumstances, the referral shall be subject to member benefits and any applicable Empire policies including any policies applicable to referrals.

Empire will track the use of nonparticipating facilities, physicians and practitioners in the instances stated above and may request a copy of the APN. Other than an occasional administrative error that can occur, your failure to provide a copy of the signed APN will result in an initial warning from Empire. At this time, Empire will not invoke a financial penalty after the initial warning but may elect to update this policy in the future. Repeated failure to comply with this policy, after initial warning, may result in termination from the Empire network.

For a complete listing of our participating physicians, please go to empireblue.com and click on "Find Care". It is important to note which network the member utilizes as a physician's participation with Empire may vary by network.

If you have any questions about the use of this form or our [Use of a Non-Participating Provider Advance Patient Notice Policy](#); please contact your Network Management Consultant. We appreciate your cooperation as we work together to ensure that your patients are active participants in decisions regarding the use of non-participating

providers in their healthcare and welcome your feedback regarding the quality and service of our existing network of participating providers.

Advance Patient Notice for Use of an Out-of-Network Breast Reconstruction Surgeon

As noted in Empire's existing "Use of a Non-Participating Provider Advance Patient Notice Policy" which became effective on October 15, 2009, it is important that our members be made fully aware of the financial implications when they are referred by their physician, on a non-emergent basis, to a non-participating provider. One particular area where we have received complaints is when members are referred by their in-network mastectomy surgeon to an out-of-network breast reconstruction surgeon when that mastectomy surgeon has recommended that reconstruction surgery be performed in the same operative session as the mastectomy.

Accordingly, Empire has adopted a separate policy entitled "[Advance Patient Notice for Use of an Out-of-Network Breast Reconstruction Surgeon](#)" to ensure that Empire's members receive prior notification of the surgeon's intent to refer to a non-participating breast reconstruction surgeon when the reconstruction surgery is to be performed in the same operative session as the mastectomy or in a separate operative session. Often, members mistakenly believe that these breast reconstruction surgeons are participating in Empire's network because their in-network mastectomy surgeon recommended or referred them to the out-of-network reconstruction surgeon. While some members may have out of network benefits, others do not. In either case, members are often surprised and unhappy, when they are presented with unexpected financial obligations for medical services.

We have also updated our Advance Patient Notice (APN) form to require advance written notice prior to the member being referred to an out-of-network breast reconstruction surgeon. This new APN form will provide Empire's members with the pertinent information to make an informed decision about coverage and options when they are being referred to an out-of-network breast reconstruction surgeon. To comply with this policy, please provide the member with the attached APN form for signature **prior to** scheduling services with or making a referral to, an out-of-network breast reconstruction surgeon, and retain the signed original in your files. This prior notification must be in the form of the enclosed APN. This new policy will require you, the mastectomy surgeon, to know whether the reconstruction surgeon participates in the network.

Example: An in-network breast surgeon is scheduling a mastectomy and plans to use an out-of-network breast reconstruction surgeon as part of the procedure. **The member must be presented with the APN form before the procedure is scheduled or the referral made so that the member can contact Empire for information about getting an exception approved for the out-of-network breast reconstruction surgeon before the referral is made and the procedure is scheduled.**

Please note that this policy does **not** apply to emergencies. Likewise, this policy does not apply when you or the member have obtained Empire's prior approval for the referral. When you or the member have contacted us and received approval in advance to proceed with an out of network service or use of an out-of-network physician you may do so without use of the APN form. As always, Empire will grant approval for the use of out-of-network physicians on an in network basis as provided in our network exception policies (such as when no in network surgeon within an appropriate service area is available) or as required under applicable law.

As noted above, once completed, the original signed form should be kept on file to be provided to Empire upon request and a copy should be given to the member. Although the use of the APN form will not be required under the circumstances identified in the paragraph above, the referral shall be subject to member benefits and any applicable Empire policies including any policies applicable to referrals. Empire will track the use of out-of-network breast reconstruction surgeons in the instances stated above. Repeated failure to comply with the APN policy, after initial warning, may result in termination from the Empire network.

For a complete listing of Empire network facilities, physicians and providers, please go to empireblue.com, or call one of our representatives.

If you have any questions about the use of the Advance Patient Notice for Use of an Out-of-Network Breast Reconstruction Surgeon form or our Use of a Non-Participating Provider Advance Patient Notice Policy; please contact your Network Management Consultant. We appreciate your cooperation as we work together to ensure that your patients are active participants in decisions regarding the use of out-of-network providers in their healthcare and welcome your feedback regarding the quality and service of our existing network.

This policy is not intended to deter patients from using their out-of-network coverage to the extent available. To the contrary, this policy is designed to ensure that, when our members receive services from an out-of-network breast reconstruction surgeon in non-emergent situations, they are involved in the decision making process,

Complaints and Grievances

If the time arises when you disagree with any of Empire's policies or services or would like to request a review of an unfavorable determination, you may file a complaint, grievance or appeal. Please refer to the information in this section to follow the proper procedures.

Complaints

A complaint is a verbal or written expression of dissatisfaction with any aspect of Empire's business operations not involving a plan decision.

If you are dissatisfied with any aspect of Empire's policies or practices relating to the delivery of services to members, you may file a complaint with Empire. To do so, you must contact Empire's Provider Services by telephone at 1-800-992-2583, 8:30 a.m. – 5:00 p.m. EST, Monday–Friday or in writing at the address below (No specific form for written complaints is required.)

Empire BlueCross BlueShield
Attn: Provider Services
PO Box 1407
Church Street Station
New York, New York 10008-1407

The complaint and any supporting documentation submitted by you will be investigated by a qualified Provider Services Representative and the results will be communicated in a written decision to you within thirty (30) calendar days of receipt of all necessary information.

This process applies to instances in which Empire is not being asked to review or overturn a previous administrative or medical management decision resulting in a claim denial, reduction in claim payment or denial of preauthorization or certification of covered services.

The processes used for those types of issues are described below.

Grievances

If you would like to dispute the payment of a claim that does not involve medical necessity, you should file a grievance with Empire. You must file your grievance within 180 days of the date of initial claims determination to the following address:

Empire BlueCross BlueShield

Attn: Provider Services
PO Box 1407
Church Street Station
New York, New York 10008-1407

In order for your claim payment grievance to be processed, the following information should be included:

- A description of why you believe the claim was not processed correctly (e.g., underpayment; incorrect payment)
- Member Name
- Member ID Number with Prefix
- Date of Service
- Provider Name, NPI and Tax ID Number
- Any other relevant info (EOB, etc).

Upon receipt of a claim payment grievance and supporting documentation, we will make reasonable efforts to issue a decision within 30 days.

If you submit your request for a claim payment grievance after the 180 day timeframe has expired, you will have waived your right to file a claim payment grievance with Empire. Empire will not accept any grievance requests after 180 days nor make any claim payment adjustments if a grievance is not submitted timely.

Please note: The above relates to the provider's ability to dispute the payment of a claim that does not involve medical necessity. There is a separate process for member grievances and/or appeals as outlined under their benefit plan and further clarified in this manual.

Coordination of Benefits

If a Member or eligible dependent is covered by more than one Health Benefit Plan, the carriers involved work together to prevent duplicate payments for any services. This cooperative effort is called Coordination of Benefits ("COB"), a provision in most Health Benefit Plans.

If a Plan is other than the primary payor, any further compensation to Provider or Facility from Plan or the Member be determined in accordance with the Agreement, the applicable Health Benefit Plan and any applicable Plan written policies and procedures for coordinating benefits. Such compensation from Plan as a secondary payer plus the amounts owed by all other sources, including the Member, shall add up to one hundred percent (100%) of the Plan rate. In cases where the primary payor is Medicare, Plan reimbursement as secondary payor will not exceed the balance after Medicare's primary payment.

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

Make the Most of Your Electronic Submissions Coordination of Benefits (COB)

Empire provides a Companion Guide, to assist Providers and Facilities with the submission of electronic Claims. The Companion Guide contains complete instructions for the electronic billing of Coordination of Benefit Claims. If you would like to learn more, refer to the Companion Guide (appropriate 837 section) online. Go to empireblue.com/provider/ Scroll down to [Electronic Data Interchange \(EDI\)](#) > Empire BlueCross BlueShield Commercial Business > *Section B – Transaction Specific Companion Documents* heading.

When filing Coordination of Benefits Claims on paper submission

Include Explanation of Benefit. (“EOB”) from primary insurance carrier with coordination of benefits (“COB”) Claims submitted for secondary payment.

Dispute Resolution and Arbitration

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

A. Attorney’s Fees and Costs

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

B. Location of the Arbitration

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

C. Selection and Replacement of Arbitrator(s)

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

D. Discovery

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

requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34.

E. Decision of Arbitrator(s)

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

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

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

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

F. Confidentiality

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

Domestic Violence – Alternate Contact Information

A new law in New York allows members who are victims of domestic violence to ask their insurer to send mail with personal information to an alternate address. Empire will honor any reasonable request to use an alternative address or alternative means of communication if a member tells us that directing coverage or claims-related information to the policyholder address poses a threat to the covered person or a child covered under the policy.

Please be sure to share this information with our members. A member can call Empire at the Member Services phone number on their Empire ID card or write to us to make a request. A notice with additional information for members, that can be printed and posted in your office, can be obtained online at empireblue.com.

Please also encourage any member who may be a victim of domestic violence to call for help.

New York State Domestic and Sexual Violence Hotlines:

- 1-800-942-6906 (English)
- 1-800-942-6908 (Spanish)
- 1-800-621-HOPE (4673) or dial 311 (In NYC)
- 1-866-604-5350 (TTY)

Empire is committed to working with our members and their providers to help our member stay safe.

Financial Institution/Merchant Fees

Providers and Facilities are responsible for any fees or expenses charged to it by their own financial institution or payment service provider.

General Definitions and Claims' Reimbursement Policies

Reimbursement for services that Providers and Facilities provide to Empire members is based upon the contracts that Empire has with its network of providers, Empire's members' benefit application, Empire's medical policy application and Empire's reimbursement guidelines. A complete listing of Empire's reimbursement guidelines and medical policies may be accessed at empireblue.com.

Compliance with Provider Manual

Provider and Facility agree to abide by, and comply with, Empire's provider manual and all other policies, programs and procedures established and implemented by Empire. Empire retains the right to add to, delete from and otherwise modify this Manual but will make good faith effort to provide notice to Provider or Facility at least ninety (90) days in advance of the effective date of material modifications. Providers and Facilities must acknowledge this Manual and any other written materials provided by Empire as proprietary and confidential. If there is a conflict with the Manual and your Agreement, your Agreement supersedes. We encourage you to contact your Empire contracting representative whenever you need clarification or if you have any suggestions for improvement to the Manual.

Payment Rules related to Coordination of Benefits

Empire, as the primary carrier, pays the full benefits under a member's contract and providers are reimbursed in accordance with applicable law. If Empire coverage is secondary, providers must first submit claims to the primary carrier. When providers receive the other plan's EOBs, they should submit claims with the EOBs to Empire. Empire's benefits are reduced by the amount paid or provided by the primary plan for the same service. Empire's payment can match but not exceed the amount which would have been paid if Empire had been primary.

Undocumented or Unsupported Charges

Per Empire policy, Plan will not reimburse Charges that are not documented on medical records or supported with reasonable documentation.

Claims' Submission Requirements

All claims submitted by provider must use the medical services codes listed in the most current version of the AMA Current Procedural Terminology (CPT) and Health Care Procedure Coding System (HCPCS) publications. The Provider or Facility must submit the medical services codes in accordance with the reporting guidelines and instructions contained in the AMA CPT, CPT Assistant, and HCPCS publications.

To facilitate efficient claims processing the appropriate, valid procedure and diagnosis codes consistent with the member's age and gender should be submitted on claims. CPT and HCPCS modifiers assist in clarifying services and determining reimbursement. Claims reporting incompatible procedures, diagnoses and modifiers may be denied. Likewise, if an unlisted or non-descript procedure code is billed electronically, (code ending in "99") the claim will be denied. If a denial is received due to a non-descript or unlisted CPT or HCPCS code was billed, a paper claim

with Medical Records attached may be submitted for consideration or the appeal process may be evoked to review the original denial.

Billing Policy and Procedure Overview

All claims must be submitted in accordance with the requirements of the provider contract, applicable member's contract, and this Provider Manual. You may not seek payment for covered services from the member, except for any applicable visit fees, co-payments, deductibles, coinsurance, or penalties as described in the member's contract. Except for co-payments, which may be collected at the time of service or discharge, you should not bill the member for any cost-sharing amounts until he/she has received an explanation of benefits (EOB). In no event should you require a deposit from a member prior to providing covered services to the member. Any Administrative charges applied by physicians must be within Empire's contractual and policies guidelines and should be prominently displayed within the office and disclosed to members prior to any services be rendered.

NYS HCRA SURCHARGE PAYMENTS

Empire has elected to make the surcharge payments required of certain claims by The New York State Health Care Reform Act ("HCRA") directly to the Office of Pool Administration (the "Pool"). However, certain claims require the provider to submit the applicable surcharge to the Pool. The Explanation of Benefits for these claims note the provider is responsible for remitting the applicable surcharge to the Pool. Empire's 835 electronic invoices display the amount of HCRA surcharge that should be remitted by the provider to the Pool based on the Member's responsibility in the Claims Adjustment Segment (CAS) of OA*137. In both cases, the amount of the surcharge is accounted for and the provider should not add such amount to the amount billed to the member. These claims are discussed below:

No surcharge remittance message present on claims:

For fixed dollar copayments and deductibles, Empire will remit the applicable surcharge directly to the Pool.

Remittance message for coinsurance with surcharge:

For coinsurance, Empire will not pay the applicable surcharge due on the Member's coinsurance nor remit such amount directly to the Pool unless the Member has met the maximum out-of-pocket limit under their contract. Instead, Empire includes the surcharge applicable to the Member's coinsurance in its Patient Responsibility amount and the provider must remit the surcharge to the Pool after collecting such amount from the Member. For example, if the Member's EOB indicates a Patient Responsibility of \$109.63; a Net Amount of \$400.00; and a Rate of \$500.00, the amount that exceeds Empire's rate should be remitted to the Pool by the provider, i.e., \$9.63 (\$509.63-\$500.00). The Provider should not bill Members for any amounts above and beyond any Patient Responsibility amounts indicated on the EOB. ***These claims have a claim level message of: An additional amount has been added to the member's coinsurance to represent the Member's share of the NYS HCRA Surcharge on this claim. The provider may not bill the Member more than this additional amount for HCRA surcharge. For most remittances, the claim will have a message code of "AIS".***

Remittance message for costshare with surcharge:

For cost sharing, Empire will not pay the applicable surcharge due on the Member's cost sharing amount nor remit such amount directly to the Pool. Instead, Empire includes the surcharge applicable to the Member's cost sharing amount in its Patient Responsibility amount and increases its payment to the provider to include any applicable surcharge. The provider must remit the surcharge to the Pool after collecting such amount from the Member. For example, if the Member's EOB indicates a Patient Responsibility of \$100.00; a Net Amount of \$408.78; and a Rate of \$500.00, the amount that exceeds Empire's rate should be remitted to the Pool by the provider, i.e., \$8.78 (\$508.78-\$500.00). The Provider should not bill Members for any amounts above and beyond any Patient

Responsibility amounts indicated on the EOB. **These claims have a claim level message code of “ASM”: An additional amount has been added to the member's costshare to represent the member's share of the NYS HCRA Surcharge on this claim. The provider may not bill the member more than this additional amount for HCRA surcharge.**

Lesser of Reimbursement

Reimbursement for Covered Services will be paid at the lesser of Physician, Practitioner or Facilities' actual charge or the amount set forth in the agreed upon negotiated allowances specific for each product, i.e. HMO, PPO, EPO, etc. The calculation of “lesser of” shall occur for at the line level for Physicians (**excluding services that are non-covered**) and at the claim level (**excluding services that are non-covered**) for Facilities.

Definition of an Admission

An Admission is considered to occur when a patient is registered as an inpatient in the Facility upon the orders of the patient's attending physician.

If the Facility decides to keep a patient receiving outpatient Covered Services (i.e. outpatient surgery, emergency room services) past midnight for observation, the overnight stay will NOT be considered an admission unless the patient is admitted as an inpatient as set forth above.

Notwithstanding the foregoing, the Facility will not be reimbursed for inpatient services unless inpatient Covered Services are deemed to be Medically Necessary. In the context of an admission, this means that such service(s) could not be safely provided on an outpatient basis and there were complications that required an inpatient level of care. Without limiting the generality of the foregoing, an admission is not Medically Necessary when a patient: (1) is being evaluated or observed to determine whether the patient has a complication or specific diagnosis for which treatment is required; or (2) when the patient is diagnosed with a complication or specific diagnosis which requires treatment and the necessary treatment (a) is reasonably expected to be less than 24 hours and (b) due to the level of acuity, could be safely provided on an outpatient basis such as services that could be provided at a facility-based observation level of care (regardless of whether the facility has a designated observation unit). In cases where it is determined that inpatient services were not Medically Necessary, Facility shall be reimbursed in accordance with the applicable outpatient rate for the Covered Services provided. Until such time as this payment provision is automated, it is the facilities responsibility to submit a corrected claim indicating an outpatient place of service for payment at the applicable outpatient rates or facility may appeal the inpatient claim as the claim will initially be denied.

Emergency Room Supply and Service Charges

The emergency room level reimbursement includes payment for all monitoring, equipment (i.e., MRI, CT, etc.), supplies, time and staff charges. Reimbursement for the use of the emergency room includes the use of the room and personnel employed for the examination and treatment of patients.

- Follow up Care – Initial emergency room includes full compensation for the subsequent follow up care by Facility employees or subcontractors in the emergency room. Empire shall not make any additional payment to the Facility, and Facility shall not seek any payment from the Member in relation to follow up care, including any payment which would otherwise be due for the emergency room visit, i.e., stitch removal, wound care, cast care, or any procedure with a CPT coding guidelines global period)
- Emergency Admissions – Unless otherwise required by federal or state law, if a Member presents in the emergency room or for an Outpatient Service, but requires a higher level of care and is admitted or transferred for Inpatient Services at Facility or another facility that i) operates under the same Facility Agreement, and (ii) has the same tax identification number as Facility, then the inpatient reimbursement shall supersede the emergency room or outpatient service allowance (there will be no separate payment

for any emergency room visit or Outpatient Service) and shall be considered all inclusive. There will be no separate payment for emergency room Covered Services but the day of admission shall be deemed to have occurred when the patient presented to the Emergency Room.

Clinic Services

For purposes of this paragraph, the term “clinic” shall mean setting for physical examination and treatment of ambulant patients who are not hospitalized and who are not treated in an emergency or ambulatory surgery setting. If Covered Services are rendered to a Covered Individual by a Professional Provider at any clinic owned, operated or controlled by a Facility, the Facility agrees that it will not bill or seek reimbursement for any claimed technical or overhead component of the clinic charges (e.g. UB-04 revenue codes 510-529 or any successor codes) from any Plan or Covered Individual, and shall only seek reimbursement of the Facility clinic charges from such Professional Provider. Until such time that Empire develops the system capability to automatically adjudicate Claims submitted for clinic charges, Empire may use a post payment audit process, which may result in recoupment of any impermissible clinic charges.

Transfers

Transfer to and from other facilities requires prior authorization by Empire’s Medical Management Department. Empire does not approve transfers between acute facilities unless the transfer is considered to be Medically Necessary. When a transfer is approved for an inpatient Covered Service for which Facility is reimbursed on a “Per Case” basis or actual charges due to “Lesser Of” reimbursement methodology (i.e. when Facility’s actual charge is less than the “Per Case” negotiated amount), reimbursement to Facility will be apportioned so as to avoid duplicate payment based on the percentage of the admission that the patient was inpatient at Facility. The per diem rate is calculated by dividing the DRG case rate by the average length of stay (GMLOS for MS DRG). For transfers for admissions for which Facility is reimbursed under a “Per Diem” payment methodology, the inpatient stay at each applicable facility shall be treated as an “Admission” as defined above and Facility shall be reimbursed under the “Admission” rules described above.

Supplies and Ancillary Services

Supplies and ancillary services are considered inclusive to the reimbursement for the primary procedure, and are not payable separately, when the primary procedure is reimbursed under a Per Case Payment Rate, Per Diem Payment Rate, Fee schedule Payment Rate or Per Visit Payment Rate payment methodology.

Incidental Procedures

Procedures that are performed concurrently with, and are clinically an integral part of, the primary procedure will not be reimbursed separately. The fees for any incidental procedure will be denied and Empire will reimburse the allowed amount for the primary procedure only. Certain services and supplies that are considered part of overall care are not separately reimbursed. These may include procedures identified as Status “B” by CMS.

Empire considers the use of surgical trays and supplies to be incidental (part of the technique) to surgical procedures and therefore not separately reimbursed. Empire’s fees for surgical procedures include these items and techniques.

Cosmetic and Reconstructive Surgery

Cosmetic surgery is not a covered service because it is performed to reshape the structure of the body in order to alter the appearance or to alter the manifestation of the aging process. Reconstructive surgery is covered when it is performed to improve or restore bodily function or to correct a functional defect resulting from disease, trauma, or congenital or developmental anomalies. When surgery is done for both cosmetic and reconstructive purposes, the allowed amount will be prorated based on the percentage of the surgery that was reconstructive in nature. However, breast reconstruction following mastectomy for cancer is not considered cosmetic. This includes surgery on the contra lateral breast for symmetry.

Home Sleep Study Policy

The Health Plan considers home sleep studies a professional service. As a result, Health Plan shall only consider reimbursement for claims billed globally on a CMS-1500 form or 837 P electronic submitted by the physician performing the reading. Claims submitted by a facility on a UB-04 claim form or 837I electronic shall not be considered for reimbursement and members shall have no liability. To the extent the physician performing the reading does not own the equipment; the physician should work with the equipment supplier directly on any related costs associated with the equipment use, as the equipment will not be reimbursed separately by the Health Plan.

For additional information on sleep studies, clinical guidelines are available at [aimspecialtyhealth.com](https://www.aimspecialtyhealth.com) or you may contact your dedicated Network Management Consultant.

Healthcare Provider Performance Evaluations

- Empire has developed certain provider evaluation and/or performance policies which includes but is not limited to:
 - The information maintained by Empire to evaluate the performance/practice of health care professionals
 - The criteria against which the performance of health care professionals will be evaluated
 - The process used to perform the evaluation
 - The information used to evaluate the providers performance will be shared with the provider to the extent applicable.
 - Empire shall make available on a periodic basis and upon the request of the provider to the extent applicable, the analysis used to evaluate the provider's performance
 - Each provider shall be given the opportunity to discuss the unique nature of the provider's professional patient population which may have bearing on the provider and to work cooperatively with Empire to improve performance

Insurance Requirements

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

1. Professional liability/medical malpractice liability insurance which limits shall comply with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render those services addressed by this Agreement. In states where there is an applicable statutory cap on malpractice awards, Providers and Facilities shall maintain coverage with limits of not less than the statutory cap.

If this insurance policy is written on a claims-made basis, and said policy terminates and is not replaced with a policy containing a prior acts endorsement, Providers and Facilities agree to furnish and maintain an extended period reporting endorsement ("tail policy") for the term of not less than three (3) years.

2. Workers' Compensation coverage with statutory limits and Employers Liability insurance.
3. Commercial general liability insurance for Providers and Facilities for bodily injury and property damage, including personal injury and contractual liability coverage.

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

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

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

- Aviation Liability insurance with limits of not less than \$1,000,000 per occurrence and \$2,000,000 in the aggregate.
- B. Providers and Facilities shall provide Empire with Evidence of Coverage (EOC) certificates upon execution of this Agreement and upon request during the Agreement Period. Providers and Facilities shall notify Empire of a reduction in, cancellation of, or lapse in coverage within ten (10) days of such a change. .

Misrouted Protected Health Information (PHI)

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

Open Practice

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

Open Dialogue

Empire places no restrictions of any kind on open dialogue between you and your patients. You are encouraged to discuss all treatment options, regardless of costs or coverage. You may also advocate on your patients' behalf, or file complaints with Empire or government agencies about our practices that you may believe affect quality or access of care.

Physician Access/Appointment Availability Standards

General Availability Standards

Members must be able to access their PCP 24 hours a day, 7 days a week. As the member's healthcare manager, the PCP is responsible for providing or arranging healthcare services on a 24/7 basis. (An answering machine does not suffice as access to the provider.) The PCP must also have a method to inform his or her Empire members about regular office hours and how to obtain care after office hours.

When off-duty or otherwise unavailable, the PCP must arrange for back-up coverage by a network physician so that appropriate medical care is available to members at all times. The PCP must have available the name, telephone number and address of the physician(s) responsible for providing back-up services to patients. The PCP should contact Empire Physician Services at 1-800-552-6630, 8:30 a.m. to 5:00 p.m. EST, Monday to Friday or Provider Data Management via fax at 1-518-367-3103 if the designated back-up changes.

The designated back-up physician(s) must participate in the same network and be a comparably trained practitioner as noted below:

Family Practice - can be backed up by a provider that with the following specialties:

- Family Practice; General Practice and/or a combination consisting of Internal Medicine – for adults and Pediatrics for Children.

General Practice - can be backed up by a provider with the following specialties:

- Family Practice; General Practice and/or a combination consisting of Internal Medicine – for adults and Pediatrics for Children.

Internal Medicine - can be backed up by a provider with the following specialties:

- Internal Medicine or Family Practice.

Pediatrics - can be backed up by a provider with the following specialties:

- Family Practice or Pediatrics

The back-up physician is responsible for communicating with the PCP about patient care he or she rendered. Documentation of all healthcare services provided by the back-up physician must be summarized in the patient's medical record including all pertinent Facility services.

If a member is out of the area and contacts Empire with an urgent or emergent situation, the patient will be informed to call his or her PCP directly. If this is not possible, the patient will be told to contact the PCP's back-up physician.

Annually, Empire will conduct an audit of the after hour availability coverage for PCP network participation to ensure compliance.

Compliance will be met if:

- A live person is reached within two phone calls.
- If an answering service is reached; compliance will be met if the service is cooperative in confirming their association with the physician and identifies how the physician can be reached (ex. pager; calls patched to physician)

In no event shall the messages refer the member to the ER unless it is a true emergency or advise to call back during normal business hours

Appointment Availability Standards

The following are considered minimums for patient accessibility. Obviously, excellent care and service will often require significantly better performance.

For HMO and POS members, the PCPs must be in the office treating patients a minimum of 16 hours a week per office location.

Patients should not wait for more than 15 minutes past their appointment time without an explanation about the delay and if necessary, provided with an opportunity to reschedule the appointment.

The physician must be able to schedule appointments within the following time frames:

Type of Appointment	Time Frame
Routine baseline physical exam	Within 4 weeks
Routine follow-up care	Within 2 weeks

Urgent Care	Within 24 hours
Non-Urgent Care	Within 5 days
Emergency Care	Within 2 hours or triage to emergency room
Initial prenatal exam	Within 3 weeks
Initial newborn exam	Within 2 weeks

Availability standards will be monitored through:

- On-site visits by Network Management Consultant,
- Review of appointment books,
- Member satisfaction surveys, and
- Member complaints

Physician, Facility and Other Healthcare Provider Responsibilities

All participating providers are expected to comply with certain standards regardless of the networks in which they participate. These include:

- Following Empire's access/appointment availability standards
- Following Empire's managed care requirements (if applicable to the member's benefit plan). Adhering to Empire's standard practice guidelines
- Submitting claims for members, accepting program/network fee schedule and not balance billing our members for covered services
- Not prohibiting members from completing Empire surveys and/or otherwise expressing their opinion regarding services received from physicians or providers
- Will not differentiate, or discriminate against any Covered Member as a result of his/her enrollment in a Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for health services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Covered Members that it does not customarily provide to others.

HMO Physicians

Physicians participating in our HMO-based networks have certain additional responsibilities, based upon their roles as primary care physicians and/or referral specialists.

Primary Care Physicians

A Primary Care Physician (PCP) is a family physician/family practitioner, general practitioner, internist or pediatrician who is responsible for delivering and/or coordinating care. PCPs must:

- Be accessible 24 hours a day, 7 days a week and provide back-up coverage
- Provide or arrange for all care delivered to HMO members
- Provide written referrals to referral specialists, to the extent required by the member's benefit plan.

Monthly Membership Reports

HMO primary care physicians (PCPs) receive a managed-care monthly membership report during the first week of every month. These reports list members who have selected the physician as their PCP. The reports contain information about members including: ID number, date of birth, co-payment and the effective date. In addition to listing current and new members, the reports list member cancellations. PCPs should review these reports and keep them on file.

For Direct HMO, a monthly report also is issued to PCPs. This report contains information about Direct HMO members' visits to specialists and notes the dates that care was delivered and the type of service. This report facilitates the PCP's awareness of specialist services being provided to the PCP's Direct HMO members.

Physicians shall maintain a minimum of 100 patients as their patient load. Physician can close their practice to new patients once this minimum level has been reached. The physician will give Empire one hundred twenty (120) days prior written notice when the physician will no longer be accepting new patients.

Referral Specialists

Providers credentialed by Empire as specialists must:

- Provide specialty care as authorized by PCP
- Obtain a referral for all members who have an HMO product, except those with Direct HMO
- Provide the member's PCP with a report on care rendered in a timely manner

PCP who also participates as a Referral Specialist

If a physician has been credentialed by Empire as both a PCP and a Referral Specialist, the following apply:

- If a member has selected the physician as their PCP, the provider cannot bill for a consultation since they are already treating the member
- If the physician is listed as a back-up to another PCP, the system will process the claim as a back-up provider and not allow a consultation unless a referral is on file.
- If the member has another physician as their PCP, the member needs to obtain a referral to the Referral Specialist

Provider Status Changes

Physicians may change their specialty status based on the needs of their patient base.

A provider could request any of the following status changes:

- Referral Specialist (RS) to PCP
- PCP to RS
- RS to Both (PCP/RS)
- PCP to Both (PCP/RS)

Requests should be sent in writing and include a copy of their board certification status for the specialties or documentation of equivalent training in the specialty. All requests should be mailed to your Network Management Consultant.

All requests are subject to approval by the Credentialing Committee. Your Network Management Consultant will communicate directly to you the decision reached by the Committee

Specialty Care Coordinator or Center

A Specialty Care Coordinator is a network Referral Specialist with experience treating the member's condition or disease that assumes the role of the PCP and provides and/or coordinates the member's primary and specialty care.

Members who have HMO-based products with a degenerative, disabling, or life-threatening condition or disease that requires specialized medical care for a prolonged period of time may select a Referral Specialist as a Specialty Care Coordinator. Such conditions include, but are not limited to: HIV/AIDS, cerebral palsy, cystic fibrosis, cancer, hemophilia, multiple sclerosis, sickle cell disease, spinal cord injury and conditions that require organ transplants.

If you are a Referral Specialist and would like to receive information on becoming a Specialty Care Coordinator for a specific member, contact Empire's Medical Management Department at 1-800-441-2411, 8:30 a.m. to 5:00 p.m. EST, Monday to Friday

Hospital Privileges

Physicians shall maintain an affiliation with at least one hospital in each network in which such Physician participates, and shall admit Covered Persons only to network hospitals when required under the terms of the Covered Person's Health Benefit Program. Physician shall inform Empire immediately in the event such affiliation with a network hospital is discontinued.

If the physician has a sole affiliation with a network hospital and the network hospital has given notice to leave the network, Empire will communicate via letter of the pending hospital termination and request that those with sole affiliation notify us or obtain alternate affiliation. The letter will also explain the potential impact on your participation status if alternate affiliations are not obtained.

In the event that alternate affiliations are not obtained, Physicians shall seek a participating PCP backup that will agree to admit your patients for inpatient care. Both the backup physician and the impacted sole affiliated physician will follow the guidelines of the Exception Backup Policy by completing the appropriate Hospital Coverage document that can be found at empireblue.com.

Physician Office Lab (POL) List

Empire will allow participating HMO, POS, PPO and EPO network physicians to perform select laboratory services in their office. The lab services are listed on the Physician Office Lab (POL) list.

The member must be referred to a participating laboratory for lab services not included on the POL list. Claims submitted to Empire for laboratory services not on the POL list will be denied and the member cannot be balance billed.

The POL list does not apply to Empire's indemnity plans. Empire's POL list can be found at empireblue.com > Find Forms> [Physician Office Lab \(POL\) list](http://empireblue.com).

Referrals

For members covered under HMO and POS plans that utilize a PCP gatekeeper, it is the responsibility of the PCP (or OBGYN for OBGYN diagnosis related illnesses or the specialty care coordinator, if applicable) to complete referral forms when authorizing services from participating referral specialists. Referral forms are available in the "Sample Forms" section of this Provider Manual or at empireblue.com.

The PCP (or OBGYN or Specialty Care Coordinator) completes a referral form for participating referral specialists' services (physician and non-physician), including office-based procedures.

No referral form is required for:

- Participating laboratory and radiology services (including ultrasounds, mammograms, CT scans and amniocentesis) Pediatrician exams of well newborns
- Routine vision exams, eyeglass lenses and frames
- No referral from the PCP is required for an OB/GYN to provide the following:
 - Two semiannual Well-Woman office exams*
 - Office-based care resulting from previous OB/GYN

- Office exams for treatment of acute gynecological conditions
- Maternity Care

* “Well-Woman Care” includes a pelvic examination, breast exam, collection and preparation of a Pap smear and laboratory and diagnostic services provided in evaluating the Pap smear.

Note: At the time of publication of this Provider Manual, the Empire products that utilize a PCP gatekeeper model are Empire HMO, Empire Direct Pay HMO, Empire Direct Pay POS and Healthy New York. Referrals are NOT required for Direct HMO, Direct POS, or Direct Share POS.

The Referral Form:

- Should indicate the reason for the referral;
- Is valid for 90 days from the effective date, unless otherwise noted*;
- Should indicate the number of visits authorized by the PCP
- Includes authorization for office-based procedures by the participating specialist (for covered and medically necessary services)
- Should have all required fields completed

Please note that a Referral Specialists may request a standing referral for any HMO member from the member’s PCP. Standing referrals are valid for up to 365 days from the date the referral is written.

The referral form serves to introduce the patient to the specialist. It gives the specialist background information and the reason for the referral. The referral form also authorizes payment to the participating specialist, provided that the services are covered and medically necessary. Visits must take place within the authorization period. If additional visits are necessary after the authorization period, a new referral form is required. Services cannot be authorized retrospectively.

All covered services performed by a participating provider during an authorized visit and within the terms of the contract are automatically authorized for that provider. For example, the provider may draw blood or perform multiple office-based services when the services are directly related to the reason for referral. This includes services with 90000 series CPT codes.

A referral is valid for only one provider. Specialists may not refer patients to other physicians. In addition, if services are to be performed at a site other than the specialist’s office (e.g., in the outpatient department of a Facility), a new referral form is required. However, this does not apply to laboratory or X-ray facilities on the specialist’s premises or in participating facilities.

In Network Referrals and Transfers

Providers shall when medically appropriate, refer and transfer Covered Members to Participating Providers and Facilities Additionally, Provider represents and warrants that he/she does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Covered Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Empire.

Referrals to Non-Participating Providers

For products with no out of network benefits, Referral requests to an out of network provider should be made through Medical Management based on the benefit plan for the member when either the network does not include an available provider with the appropriate training and experience to meet the needs of the member or medically necessary services are not available through the network providers. The referral will be reviewed by Empire for medical appropriateness and an approval or denial provided.

For non-emergent service the member may not use a non-participating provider unless there is no specialist in the network that can provide the required treatment.

If you need to request an out of network referral, contact Empire's Medical Management Department at 1-800-441-2411, 8:30 a.m. to 5:00 p.m. EST, Monday to Friday.

Refund Provisions

Provider and Facility Refund Policy

In the event that Empire makes an overpayment, erroneous payment or a payment which otherwise exceeds the amount of the contractual obligation of the Agreement, Empire will provide Provider or Facility with thirty (30) days' notice and Provider or Facility shall refund such payment to Empire or obtain Empire's consent to an alternative payment arrangement on or before the expiration of the thirty (30) day notice period. In the event Provider or Facility fails to refund or repay any amounts owed to Empire within the thirty (30) days and the amount is not appealed, then Empire shall then be permitted to offset such refund amounts from other claims or to reach an agreement with Provider or Facility as to a schedule for repayment of such funds. Notice shall not be required for routine adjustments of claims (i.e., duplicative payments or claims payment errors).

Subject to the below exception, no later than two (2) years after full payment to Provider or Facility, Empire may subsequently review the appropriateness of any bill and Claim payment of a clinical nature; provided, however, that Empire shall notify Provider or Facility of the particular case under review within thirty (30) days of the commencement of such review and such review shall be completed and notice of the results provided to Provider or Facility no later than one hundred twenty (120) days after it was commenced. Notwithstanding the foregoing, for Empire's State of New York group customers, City of New York group customers and for the Federal Employee Benefit Program, the post payment review period shall be expanded to six (6) years from the end of the calendar year in which the Claim was submitted. The notice from Empire shall state the specific reason(s) why Empire believes the initial payment determination was incorrect and/or request all additional information needed by Empire to review such determination. Notwithstanding the foregoing, the above listed time limits shall not apply to overpayment recovery efforts that are (1) based on reasonable belief of fraud or other intentional misconduct, or abusive billing, (2) required by, or initiated at the request of, a self-insured plan, or (3) required or authorized by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members.

Negative Payment Adjustments

The process of reducing future payments by the amount that was adjusted or overpaid is called "negatively adjusting the facility's account." This is done by systematically retracting a claim payment and placing a "negative balance" on the facility's account. The EOB will show a minus sign next to the "Payment" column. When this occurs, the overpayment should be removed from the account(s) in question and used to credit the other accounts paid on the remittance advice.

A large retraction may not be satisfied on one EOB. Occasionally, a negative balance will carry over to future EOBs. When this occurs, the EOB will show claim payments but no check will be issued. The total amount paid will appear at the end of the EOB in the "Net Amount Paid" field.

The "Adjustment from Previous Balance" field will indicate how much money from the previous retraction should be used to satisfy the accounts that appear on this EOB. The original retraction will not be shown on each individual EOB; it will appear only on the EOB from which it was originally taken.

It is very important to keep track of the original retraction so that all of the accounts involved may be correctly credited.

You should contact Provider Services with any questions about payment adjustments. Please have the following information ready before calling:

- Your Provider or Facility's tax identification number
- Your six-digit Medicare provider number or your National Provider Identifier (NPI) number
- The member's identification number
- The patient's name, date of birth, date of service and claim number (if available)

This information will help to expedite your request. Provider Services is available at 1-800-992-BLUE (2583) Monday – Friday, 8:30 am – 5:00 pm.

Risk Adjustments

Compliance with Federal Laws, Audits and Record Retention Requirements

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

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

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

Encounter Data for Risk Adjustment Purposes

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

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

Maintaining documentation of Members' visits and of Members' diagnoses and chronic conditions helps Empire fulfill its requirements under the Affordable Care Act. Those requirements relate to the risk adjustment, reinsurance and risk corridor, or "3Rs" provision in the ACA. To ensure that Empire is reporting current and accurate Member diagnoses, Providers and Facilities may be asked to complete an Encounter Facilitation Form (also known as a SOAP note) for Members insured under small group or individual health benefit plans suspected of having unreported or out of date condition information in their records. Empire's goal is to have this information confirmed and/or updated no less than annually. As a condition of the Facility or Provider's Agreement with Empire, the Provider or Facility shall comply with Empire's requests to submit complete and accurate medical records, Encounter Facilitation Forms or other similar encounter or risk adjustment data in a timely manner to Empire, Plan or designee upon request. Providers and Facilities also agree to cooperate with Empire's, or its designee's, requests to reach out to patients to request appointments or encounters so additional information can be collected to resolve any gaps in care (example - blood tests in certain instances) and to provide

the updated and complete Member health information to Empire to help it fulfill its requirements under the Affordable Care Act.

In addition to the above ACA related commercial risk adjustment requirements, Providers and Facilities also may be required to produce certain documentation for Members enrolled in Medicare Advantage or Medicaid.

RADV Audits

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

ICD-10 CM Codes

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

Medical Record Documentation Requirements

Medical records significantly impact risk adjustment because:

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

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

HHS record documentation requirements include:

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

Transitional Care for New Enrollee

If a member has a life-threatening disease or condition or a degenerative and disabling disease or condition, the transitional period is up to 60 days. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include provision of post-partum care related to the delivery.

Directory of Services/Provider Resource Information

Empire is committed to helping you with hassle-free healthcare administration by providing you with the information you need, when you need it. In this section you will find a:

- Quick Guide to Useful Contact Information – Important phone numbers and addresses to help in your day-to-day interactions with Empire
- Empire Product Chart
- The Provider Services Roadmap
- New York City Claim Submission Guidelines
- New York State Claim Submission Guidelines

Quick Guide to Useful Contact Information

Purpose	Direct HMO	MediBlue/ Medicare Advantage	POS Direct POS	EPO PPO	BlueCard PPO (for Out-of-Area Members Only)	Traditional indemnity
Precertification Case Management Out-of-Network Referrals	Empire Medical Management Phone: 1-800-441-2411 Fax: 1-800-241-5308	Medicare Advantage Medical Management Phone: 1-877-657-6115 Fax: 1-800-464-5942	Empire Medical Management Phone: 1-800-441-2411 Fax: 1-800-241-5308	Empire Medical Management Phone: 1-800-982-8089	1-800-676-BLUE (25830)	Refer to Member's ID Card
Claims Status/Review Patient Eligibility Order Referral Forms	Provider Services 1-800-992-BLUE (2583)				Claims Status/Review 1-800-713-4173 Eligibility: 1-800-676-BLUE (2583)	Empire Provider Services 1-800-343-7283
Claims Submission	Empire PO Box 1407, Church Street Station New York, NY 10008-1407 Include Prefix				Empire BlueCard PPO Program PO Box 3877, Church Street Station New York, NY 10008-3877 Include Prefix	Empire PO Box 1407, Church Street Station New York, NY 10008-1407 Include Prefix
Referral to Network Providers	PCPs fax referral to: 1-800-522-5793 Or mail referral to: Empire PO Box 1407, Church Street Station New York, NY 10008-1407 NO REFERRALS REQUIRED FOR DIRECT HMO AND MEDIBLUE PLANS				Not applicable	Not applicable
Electronic Claim Submissions	Electronic Commerce Service: 1-866-889-7322					
Behavioral Health / Substance Abuse	Behavioral Health Management Program 1-800-626-3643				Refer to Member's ID Card	
Change your Directory Listing/ Other Provider File Information	Attn: Provider Registry (PDM) PO Box 1407, Church Street Station New York, NY 10008-1407 or Fax: 1-877-281-6713 Include your NPI or Empire Provider ID					
Empire Maternity Care (For PCPs and Ob/Gyns)	Empire Medical Management Phone: 1-800-845-4742				Not applicable	Not applicable
Member Questions	Refer to Member's ID Card					

2020 PRODUCT GUIDE

This guide is general information only; actual information varies depending on group, network and other requirements

LARGE GROUP			
Group	Network Name	Full Product Name	Prefix
Large Group	HMO*	Empire HMO Empire Direct HMO	YLL YLN YLT
Large Group	POS*	Empire POS Empire Direct POS	JPC VEH YLF YLN YLQ
Large Group	PPO/EPO	Empire PPO Empire PPO with HRA Empire PPO with HSA	NIW
Large Group	EPO	Empire EPO Empire EPO with HRA Empire EPO with HSA	VQA
Large Group	Blue Priority	Empire Prism Blue Priority Empire Blue Priority EPO	BPR NYH VQB VQC
Large Group	EPO	Empire Blue Priority EPO with HRA Empire Blue Priority EPO with HSA	QBP
Large Group	EPO	Total Blue EPO with HRA Total Blue EPO with HSA	YEW
Large Group	PPO	Total Blue PPO with HRA Total Blue PPO with HSA	YEW
Large Group	Indemnity	Indemnity	NIX
*Gatekeeper Models require PCP and Referrals to Specialists			

LARGE GROUP CONTINUED			
Group	Network Name	Full Product Name	Prefix
Large Group	Blue Access	Empire Blue Access PPO with HRA Empire Blue Access PPO with HSA Empire Blue Access PPO	CFT
Large Group	Blue Access	Empire Blue Access GEPO with HSA* Empire Blue Access GEPO with HRA* Empire Blue Access GEPO*	KIG
Large Group	Blue Access	Empire Blue Access EPO with HRA Empire Blue Access EPO with HSA Empire Blue Access EPO	KIH
Large Group	Connection	Empire Connection EPO	CJL
Large Group	Connection	Empire Connection GEPO*	CJV
*Gatekeeper Models require PCP and Referrals to Specialists			

SMALL GROUP PRODUCTS			
Group	Network Name	Full Product Name	Prefix
Small Group	Blue Access	Empire Bronze Blue Access EPO Empire Gold Blue Access EPO Empire Platinum Blue Access EPO Empire Silver Blue Access EPO	YXE
Small Group	Blue Access* (Gatekeeper Model)	Empire Bronze Blue Access GEPO* Empire Gold Blue Access GEPO* Empire Platinum Blue Access GEPO* Empire Silver Blue Access GEPO* Empire Gold Healthy New York Blue Access GEPO	XNU
Small Group	Blue Access X	Empire Platinum Blue Access X GEPO*	BAW
Small Group	Blue Access	Empire Blue Access HMO with HSA*	YXC
SMALL GROUP PRODUCTS CONTINUED			

SMALL GROUP PRODUCTS CONTINUED			
Small Group	Blue Access	Empire Gold Healthy New York Blue Access HMO	YXD
Small Group	PPO/EPO**	Empire Silver EPO Empire Silver EPO W/HSA	ZVF
Small Group	PPO/EPO	Empire Silver PPO W/HSA Empire Platinum PPO 80th Percentile FAIR Health	ZYL
Small Group	Connection	Empire Silver Connection X GEPO*	BKT
Small Group	Connection	Empire Bronze Connection GEPO w/HSA* Empire Platinum Connection GEPO*	XBJ
Small Group	Connection	Empire Platinum Connection EPO Empire Silver Connection EPO w/HSA	XBJ
Small Group	Blue Priority	Empire Silver Blue Priority EPO Empire Bronze Blue Priority Empire Platinum Blue Priority EPO Empire Gold Blue Priority EPO	QBP
Small Group	Blue Priority	Empire Silver Blue Priority EPO Empire Bronze Blue Priority EPO Empire Platinum Blue Priority EPO Empire Gold Blue Priority EPO	QBP
Small Group	Blue Priority	Empire Gold Blue Priority EPO w/HSA Empire Silver Blue Priority EPO w/HSA Empire Bronze Blue Priority EPO w/HSA	QBP
*Gatekeeper Models require PCP and Referrals to Specialists			

INDIVIDUAL NETWORK			
Group	Network Name	Full Product Name	Prefix
Individual	Individual Network	HealthPlus Gatekeeper X, Bronze* HealthPlus Gatekeeper X, Catastrophic* HealthPlus Gatekeeper X, Gold* HealthPlus Gatekeeper X, Platinum* HealthPlus Gatekeeper X, Silver*	VFG
Individual	Individual Network	HealthPlus Gatekeeper Bronze HealthPlus Gatekeeper, Catastrophic HealthPlus Gatekeeper, Gold HealthPlus Gatekeeper, Platinum HealthPlus Gatekeeper, Silver	VJD
*Gatekeeper Models require PCP and Referrals to Specialists			

GOVERNMENT SPONSORED PRODUCTS			
Group	Network Name	Full Product Name	Prefix
Medicare	Medicare Advantage HMO Group Sponsored	Empire MediBlue Empire MediBlue Essential	AAN VOM
Medicare	Medicare Advantage HMO Individual*	Empire MediBlue Core	VOF
Medicare	Medicare Advantage POS Individual*	Empire MediBlue Choice	VOF
Medicare	Medicare Advantage PPO Group Sponsored	Empire MediBlue Freedom	XLU
Medicare	Medicare Advantage PPO Individual	Empire MediBlue Access	VOG
Medicare	Medicare Advantage PSP*	Empire MediBlue Select (HMO) Empire MediBlue Dual Advantage Select	M8H E6D
Medicare	Medicare Advantage DSNP*	Empire MediBlue Dual Advantage	JWX
** The member's PCP is also responsible for referring the member to a specialist. The Primary Care Physician should refer the member to an in-network specialist and notate the referral in the member's chart. The PCP is not required to notify the plan of the referral.			
Medicaid	Medicaid	Empire BlueCross BlueShield HealthPlus Medicaid	JLJ
Medicaid	Child Health Plus	Empire BlueCross BlueShield HealthPlus Child Health Plus	JLJ
Medicaid	Essential Plan	Empire BlueCross BlueShield HealthPlus Essential Plan	JLJ
Medicaid	HARP	Empire BlueCross BlueShield HealthPlus HARP	JLJ
Federal	Federal Employee Plan (FEP)	Federal Employee Plan (FEP)	R
*Gatekeeper Models require PCP and Referrals to Specialists			

NATIONAL ACCOUNTS			
Group	Network Name	Full Product Name	Prefix
National Account	EPO	Empire HRA Gold Empire HSA Gold Empire HSA Silver	Various
National Account	EPO	Anthem HRA Gold Anthem HSA Gold Anthem HSA Silver	Various
National Account	EPO	Empire EPO	Various
*Gatekeeper Models require PCP and Referrals to Specialists			

Your Agreement sets forth the applicable Empire Rate for all Health Benefit Plans with which Facility or Provider is participating, as indicated on the signature page of the Agreement, for purposes of the PCS and the PCS Attachment the terms are defined as follows:

The "**Group**" rates shall apply to all large group PPO, HMO, POS, EPO, all small group PPO Health Benefit Plans, and Indemnity Health Benefit Plans issued by Empire, which may access the following Plan Networks, including but not limited to: HMO, PPO, EPO, Blue Priority (PPO), and Indemnity. The "**Small Group**" rates (previously referred to as the "Pathway" rate) shall apply to all small group HMO, POS and EPO Health Benefit Plans issued by Empire, which may access the following Plan Networks, including but not limited to: Blue Priority (non-PPO)






The "**Individual**" rates shall apply to all Individual Health Benefit Plans issued by Empire.

***This list is not inclusive of all of Empire's plans.**






Physician Office Roadmap

This Physician Office Roadmap can be used to guide you to the correct department to assist with daily administrative functions.

Provider Services 1-800-992-BLUE (2583)

- Confirm patient benefits and eligibility 
- Obtain patient coinsurance and deductible information 
- Check the status of a patient referral
- Obtain the status of claim payment 
- Initiate a claim review 
- Obtain information on how to file a formal appeal 
- Check the status of an appealed claim
- Check the status of check
- Inquire about the timely filing of a claim
- Follow up on a request for medical records

National Provider Solutions (Network Management Consultants)

- Obtain information on Empire's Products and Services 
- Questions about Empire's policies and procedures 
- Register and schedule training on the Empire Provider Website - Webinar
- Provide educational materials to newly credentialed providers
- Request clarification on Empire's Medical or Payment Policies 
- Request information on how to obtain fee schedule information 
- Ask general questions about Empire's Practitioner Agreement
- Request educational materials such as the Provider sourcebook and Provider Quick Guides, Newsletters 
- Obtain the status of credentialing

To reach your dedicated Network Management Consultant:

Please Call: **800-992-BLUE (2583)** and select the following prompts in order:


- Option 1: Medical Providers
- Option 4: Updates and Other Information
- Option 1: Participation and Credentialing Information
- Enter your zip code

BlueCard (Out of Area Member)

Claims Status/ Review 1-800-713-4173

Eligibility 1-800-676-BLUE (2583)

- Confirm patient eligibility for an out of area member
- Obtain member liability for out of area members
- Obtain pre-certification for Blue Card members

- Ask questions regarding the Alpha-Prefix on the member's card
- Obtain member policy information on covered benefits
- Request Out of area member Explanation of Benefits
- Obtain status for Blue Card Claims
- Request general information 

EDI 1-866-889-7322

- Request EDI registration information and forms
- Obtain EDI contacts and support information
- Obtain information on the EDI transaction sets supported by EBCBS
- Request approved Clearinghouse and Vendor Listing
- Obtain information about the Empire/MD ONLINE partnership
- Obtain guides regarding TCP/IP and E-Link
- Obtain Front end Validation Manuals
- Ask questions on the EDI EMC Receipt Report
- Ask questions on how to submit electronically
- Ask general questions about electronic remittances

Provider Demographic Updates

To request demographic changes or changes in a Tax Identification Number, forms are available for download Availity.com/Payer Spaces/Empire BlueCross BlueShield/Resources/ [Provider Maintenance](#) Form

Mail to:

Empire Provider Data Management
PO Box, 1407, Church Street Station
New York, NY 10008-1407.
Include your NPI

New York City Account – Claim Submission Guide

The purpose of this guide is to help determine which insurance carrier to send a claim to for certain hospital versus medical services. For instructions on how to submit a claim to Empire, see our claim submission references on our website.

In some instances, Empire is responsible for payment of both the Hospital and Medical benefits for certain New York City accounts. For group

numbers starting with 157800, 157801, 157802, and 157803, Empire pays for Hospital and Medical benefits and does not split coverage.

In some circumstances, Empire splits coverage for New York City accounts and is NOT responsible for payment of both Hospital and Medical benefits. The following grid does not include all of the New York City account plans but rather reflects the PPO Hospital-Only Contracts for groups starting with 157000 to 157699. The services described pertain to Empire Primary non-Medicare members, retirees and their dependents.

While this grid is provided as a general guideline for where to submit claims, you should refer to the Empire Web site for additional information or to the telephone number located on the member's ID card if you have particular claim submission questions.

Service Rendered	EBCBS	GHI Health Plan	Notes
Alcohol Detox/Rehab (IP or OP)			
Hospital		Submit to GHI	
Physician		Submit to GHI	
Ambulance by Air			
	Submit to Empire		
Ambulance by Air, Facility to Facility			
	Submit to Empire		
Ambulance by Land			
		Submit to GHI	
Ambulance by Land, Facility to Facility			
			Not Covered
Ambulette			
		Submit to GHI	
Blood			
Services rendered in the outpatient department of the hospital	Submit to Empire		Must be billed by a hospital and the hospital has incurred expenses for blood and blood products.
Take home blood, blood products and blood derivatives for Hemophiliacs	Submit to Empire		
Cancer Chemotherapy			
Outpatient	Submit to Empire		

Inpatient	Submit to Empire		Pre-cert Required by NYC Healthline. Benefits available based on medical necessity as determined by NYC Healthline.
Cardiac Rehab (IP or OP)			
	Submit to Empire		Pre-cert Required by NYC Healthline. Benefits only available if authorized by NYC Healthline.
Clinic			
		Submit to GHI	
DME (IP or OP)			
		Submit to GHI	
Drug Detox/Rehab (IP or OP)			
Hospital		Submit to GHI	
Physician		Submit to GHI	
Emergency Room Services			
If bundled in rates	Submit to Empire		
If unbundled			
Hospital	Submit to Empire		
Physician	Submit to Empire		Emergency Room services for certified emergency physicians, noninvasive cardiology, noninvasive pathology, noninvasive radiology. All others, submit to GHI.
For medical services rendered with psychiatric component	Submit to Empire		
Psychiatric only		Submit to GHI	
Hemodialysis			
Outpatient	Submit to Empire		Pre-cert Required by NYC Healthline for initial approval. Benefits available in a hospital or in a participating approved free standing facility.
Inpatient	Submit to Empire		Pre-cert Required by NYC Healthline. Benefits available based on medical necessity as determined by NYC Healthline.
Homecare			
		Submit to GHI	

Hospice Care			
	Submit to Empire		
Hyperbaric Oxygen Therapy			
	Submit to Empire		Pre-cert Required by NYC Healthline. Benefits available based on medical necessity as determined by NYC Healthline.
Infusion Therapy (Non-Cancer)			
Outpatient	Submit to Empire		
Inpatient	Submit to Empire		Pre-cert Required by NYC Healthline. Benefits available based on medical necessity as determined by NYC Healthline.
Inpatient Hospital			
Facility - Inpatient Emergency Admission	Submit to Empire		Notification of admission required through NYC Healthline. Benefits available based on medical necessity as determined by NYC Healthline. Patient is responsible for ER admit notification within 48 hours. Hospital may notify on patient's behalf.
Facility - Inpatient Elective Admission	Submit to Empire		Pre-cert Required by NYC Healthline. Benefits available based on medical necessity. Patient is responsible for admission pre-cert. Hospital may pre-cert on patient's behalf.
Physician		Submit to GHI	
IVF			
		Submit to GHI	
Laboratory			
Hospital (OP)			
If part of payable OP claim/procedure	Submit to Empire		
If NOT part of OP payable claim/procedure		Submit to GHI	
Physician Claims:			
If unbundled (OP):			
Physician - Non-emergency Room		Submit to GHI	
Physician - Emergency Room	Submit to Empire		For non-invasive pathology Emergency Room services only.

If Bundled (OP or IP)			
Physician	Submit to Empire		
If Unbundled (IP)			
Physician		Submit to GHI	
Maternity Encounters			
Inpatient Admissions	Submit to Empire		Pre-cert Required by NYC Healthline for maternity admit if stay is greater than 48 hours for vaginal delivery or greater than 96 hours for c-section delivery.
Labor and Delivery urgent outpatient services	Submit to Empire		Empire does not require notification when the urgent visit is for a labor and delivery evaluation where the patient remains outpatient.
Scheduled outpatient services - such as, ultrasounds and non-stress tests		Submit to GHI	
Behavioral Health Services			
		Submit to Beacon	GHI's Behavioral Management Program/ Beacon Health- 1-888-447-2526
Nutritional Counseling			
		Submit to GHI	
Outpatient Diagnostic testing/procedures			
EPS		Submit to GHI	
TEE – Diagnostic		Submit to GHI	
Cardio version	Submit to Empire		
Outpatient Surgery - Both Free Standing or Hospital Based Ambulatory Surgery Center or Unit, Same Day Surgery			
Hospital/Facility	Submit to Empire		Pre-cert Required by NYC Healthline for the following procedures: possible/cosmetic procedures, reconstruction, outpatient transplants, optical/vision related procedures, breast reconstruction, cochlear implants, functional endoscopy/nasal surgery, spinal stimulator implants, joint replacements, experimental/investigational procedures, hyperbaric oxygen chamber, infertility with underlying condition, pain management, stimulatory implants, wound vac, bariatric surgery, and spinal surgery.
Physician		Submit to GHI	
Pharmacy			

Outpatient	Submit to Empire		Not covered unless part of a payable outpatient claim. All non-experimental drugs and medicines that are available for purchase and readily obtainable. Take home drugs not covered.
Inpatient	Submit to Empire		Not covered unless part of a payable inpatient claim. All non-experimental drugs and medicines that are available for purchase and readily obtainable. Take home drugs not covered.
Physical Therapy			
Rehabilitation Hospital or Specialty Facility (IP)	Submit to Empire		See SNF
Rehabilitation Hospital or Specialty Facility (OP)		Submit to GHI	Pre-cert by NYC Healthline after the 16th visit.
Preadmission Testing/Presurgical Testing			
	Submit to Empire if:		<p>A. The tests are ordered by a physician as a preliminary step to an inpatient or outpatient surgery encounter; and</p> <p>B. The testing is necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; and</p> <p>C. There is a scheduled reservation for the hospital and for the operating room before the tests are performed; and</p> <p>D. The patient is physically present at the hospital when the tests are performed; and</p> <p>E. Surgery actually takes place within 21 days after the tests are performed./Surgery is cancelled as a result of the preadmission tests./Surgery is cancelled due to an unrelated condition that manifests after completed PST/PAT where the new condition prevents surgery.</p>

Radiation Therapy (IP)			
Hospital		Submit to GHI	
Physician		Submit to GHI	
Radiation Therapy (OP)			
Hospital		Submit to GHI	
Physician		Submit to GHI	
Radiology			
Hospital (OP)			
If part of payable OP claim	Submit to Empire		
If NOT part of OP payable claim/procedure		Submit to GHI	
Physician Claims:			
If unbundled (OP):			
Physician - Non-emergency Room		Submit to GHI	
Physician - Emergency Room	Submit to Empire		
If Bundled (OP or IP)			
Physician	Submit to Empire		
If Unbundled (IP)			
Physician		Submit to GHI	
Mammograms – Screening	Submit to Empire		Only 1 annual routine mammography screening per calendar year in hospital
Mammograms – Diagnostic		Submit to GHI	
Skilled Nursing Facility			
SNF	Submit to Empire		Pre-cert Required through NYC Healthline. Up to 90 days per calendar year. NYC Healthline may substitute benefits if medically appropriate. 2 ½ outpatient visits=1 day in a SNF. 1 day in an acute rehabilitation facility =2 days in a SNF. Of the 90 days there are 30 occupational and speech therapy visits combined allowed.
Physician		Submit to GHI	
Transplants			
IP	Submit to Empire		Precert Required by NYC Healthline. Benefits available based on medical necessity as determined by NYC Healthline.
OP	Submit to Empire		No precert for outpatient.
Wound Care – Outpatient			
If surgical debridement is performed	Submit to Empire		
If no surgical debridement is performed		Submit to GHI	

NEW YORK STATE HEALTH INSURANCE PROGRAM

Claim Submission Guide

The purpose of this guide is to help determine which insurance carrier to send a claim to for certain hospital versus medical services. To qualify for payment all services must be medically necessary. This document is specific to New York State Health Insurance Program members only – Prefix YLS

Alcohol Detoxification/Rehabilitation Inpatient

If a portion of an inpatient stay is deemed to be medical or detoxification in nature, Empire would be liable for the medical days only.	Submit to Empire		Coverage for medical or detoxification services only. Note: If facility is paid a case rate which includes all IP days, behavioral health days should not be billed to the mental health substance abuse (MHSA) carrier. Hospital should, however, contact MHSA carrier to notify of admission.
The behavioral health segment of an Inpatient stay is the liability of the mental health substance abuse carrier.		<p>Admit dates prior to 1/1/14: Submit to OptumHealth</p> <p>Admit dates 1/1/14 and after: Submit to ValueOptions</p> <p>Admit dates 1/1/16 and after: Submit to Beacon Health Options (formerly ValueOptions)</p>	Coverage for services for mental health and substance abuse care, including care for alcoholism.

Alcohol Detoxification/Rehabilitation Outpatient

		<p>Admit dates prior to 1/1/14: Submit to OptumHealth</p> <p>Admit dates 1/1/14-12/31/15: Submit to ValueOptions</p> <p>Admit dates 1/1/16 and after: Submit to Beacon Health Options (formerly ValueOptions)</p>	
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Ambulance/Ambulette/Air Ambulance

Owned and operated by a hospital.	Submit to Empire		The service must be owned, operated, and billed for by a hospital. Ambulance transportation from facility to facility must meet same criteria.
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Not owned by a hospital, volunteer or professional ambulance.		Submit to UnitedHealthcare	February 2021
Blood			
Services rendered in the outpatient department of the hospital.	Submit to Empire		Must be billed by a hospital and the hospital must have incurred expenses for blood and blood products.
Take home blood, blood products, and blood derivatives for hemophiliacs.	Submit to Empire		
Contact UHC's HCAP program if related to home care services.		Submit to UnitedHealthcare	The Home Care Advocacy Program (HCAP) is The Empire Plan program for home care services, durable medical equipment and certain supplies. HCAP is administered by UnitedHealthcare.
Bone Density			
Hospital (OP)	Submit to Empire		
Cancer Chemotherapy (IP or OP)			
Chemotherapy Administration (IP or OP)	Submit to Empire		Treatment must be ordered by a physician. Mode of administration can be intravenous, oral, subcutaneous, or intramuscular. Covered only if the hospital setting is medically necessary. No outpatient copayment applies.
Chemotherapy Related services not on the same day as chemotherapy administration (OP RX services, Diagnostic Services)	Submit to Empire		Diagnostic testing will continue to be covered by Empire. Drugs are covered if billed with a chemo related service, (ie. 280, 761) with a cancer diagnosis and a history of chemotherapy within twelve months of the date of service.
Cancer Resource Services (CRS)			
For hospitals who participate in UnitedHealthcare's Centers of Excellence for Cancer Program received through a nationwide network known as Cancer Resource Services (CRS). Patients must be registered.		Submit to UnitedHealthcare	For cancer related treatments only. Contact the CRS program at United to determine the patient's eligibility for the program.

			1-877-7-NYSHIP (1-877-769-7447) and press or say 1 on the main menu for United Healthcare, then 5 for Cancer Resource Services.
Cardiac Rehab			
Outpatient cardiac rehab		Submit to UnitedHealthcare	
Clinic (Hospital Owned and Operated)			Hospital must own AND bill for services performed. Benefits are provided to the same extent as services performed in the outpatient department of a hospital, subject to applicable copayments.
Single Line Clinic Claim – Medicare Primary		Submit to UnitedHealthcare	
Clinic visit for venipuncture		Submit to UnitedHealthcare	Venipuncture is the only service (except medical care) billed on the service date.
Clinic billing medical care and another covered outpatient service (lab, radiology, surgery, chemo, etc)	Submit to Empire		
Clinic billing services other than medical care or venipuncture	Submit to Empire		
Drug Detoxification IP			
If a portion of an inpatient stay is deemed to be medical or detoxification in nature, Empire would be liable for the medical or detoxification days only.	Submit to Empire		<p>Coverage for medical or detoxification services only.</p> <p>Note: If facility is paid a case rate which includes all IP days, behavioral health days should not be billed to the mental health substance abuse (MHSA) carrier. Hospital should, however, contact MHSA carrier to notify of admission.</p> <p>If facility is paid a per diem rate, the behavioral health days should be billed to the MHSA carrier.</p>
The behavioral health segment of an inpatient stay is the liability of the mental health substance abuse carrier.		<p>Admit dates prior to 1/1/14: Submit to OptumHealth</p> <p>Admit dates 1/1/14-12/31/15: Submit to ValueOptions</p> <p>Admit dates 1/1/16 and after:</p>	Coverage for services for mental health and substance abuse care, including care for alcoholism.

		Submit to Beacon Health Options (formerly ValueOptions)	February 2021
Drug Rehabilitation OP			
		Admit dates prior to 1/1/14: Submit to OptumHealth Admit dates 1/1/14-12/31/15: Submit to ValueOptions Admit dates 1/1/16 and after: Submit to Beacon Health Options (formerly ValueOptions)	
Durable Medical Equipment			
		Submit to UnitedHealthcare	
Emergency Room			
Unbundled Hospitals—Associated professional charges for ER physician, pathology, radiology		Submit to UnitedHealthcare	
If ALL diagnosis codes on the ER claim are mental health or alcohol/substance abuse		Admit dates prior to 1/1/14: Submit to OptumHealth Admit dates 1/1/14-12/31/15: Submit to ValueOptions Admit dates 1/1/16 and after: Submit to Beacon Health Options (formerly ValueOptions)	
Hemodialysis			
Hospital (OP)	Submit to Empire		Treatment must be ordered by a physician, no copayment applies.
Homecare			
Home Care Services		Submit to UnitedHealthcare	Contact the Home Care Advocacy Program (HCAP) through UHC.

Hospice	Submit to Empire		February 2021
Hyperbaric Oxygen Therapy (HBOT)			
Hyperbaric Oxygen Therapy as sole service or NOT rendered as part of an emergency room or surgical service, such as wound debridement for dates of service prior to 1/1/20.		Submit to UnitedHealthcare	
Hyperbaric Oxygen Therapy rendered as part of an emergency room or surgical service, such as wound debridement for dates of service prior to 1/1/20.	Submit to Empire		
Hyperbaric Oxygen Therapy for dates of service on/or after 1/1/20	Submit to Empire		
Immunizations			
Hospital (OP)	Submit to Empire		
Infusion Therapy (non-cancer)			
IV Therapy	Submit to Empire		Administration of Desferal for treatment of Cooley's Anemia must be ordered by a physician and must be performed in a hospital qualified to perform the service as determined solely by EBCBS.
Inpatient Hospital			
Facility (up to Empire Plan covered benefits) Emergency Inpatient Admissions.	Submit to Empire		Precertification and notification of ER admissions through Empire is required within 48 hours or as soon as reasonably possible. Call can be made by the member or by anyone on the member's behalf.
Facility (up to Empire Plan covered benefits) Elective Inpatient Admissions.	Submit to Empire		Precertification is required through Empire for elective admissions. Call can be made by the member or anyone on the member's behalf.
Facility (up to Empire Plan covered benefits) Maternity Inpatient Admissions.	Submit to Empire		Precertification is required through Empire as soon as the pregnancy is confirmed; The member is encouraged to also call just prior to delivery. Call can be made by the member or by anyone on the member's behalf.

Facility (after Empire Plan covered benefits are exhausted, except SNF)		Submit to UnitedHealthcare	When Empire Plan covered benefits are exhausted, submit inpatient claims through basic medical coverage to UHC. This does not apply to SNF claims as UHC will not consider after EBC benefits have been exhausted)
InVitro Fertilization (IVF)			
Service rendered by a UnitedHealthcare Infertility Center of Excellence.		Submit to UnitedHealthcare	IVF is a shared benefit between Empire and UHC up to a \$25,000 or \$50,000 lifetime maximum expense for qualified procedures. IVF fertility COE program is administered by United Healthcare (UHC). IVF services must be preauthorized by UHC. Contact the IVF program at UHC to determine the patient’s enrollment in the program.
Service NOT rendered by a UnitedHealthcare Infertility Center of Excellence	Submit to Empire		
Laboratory			
Hospital (OP) non-routine	Submit to Empire		Empire submissions: Patient MUST be physically present in the outpatient department. This means the specimen was taken in the outpatient department of the hospital.
Hospital (OP) routine pap and prostate screening (billed with routine diagnosis)	Submit to Empire		
Hospital (OP) all other routine labs		Submit to UnitedHealthcare	
Physician draws blood in the office and sends sample to hospital.		Submit to UnitedHealthcare	Type of bill code 141 signifies patient was NOT physically present UNLESS venipuncture is billed.
Venipuncture only (drawing station).		Submit to UnitedHealthcare	
Maternity Encounters			
Inpatient Admissions	Submit to Empire		Precertification is required through Empire as soon as the pregnancy is confirmed. Members are encouraged to call back just prior to delivery.
Behavioral Health Services			

		Admit dates prior to 1/1/14: Submit to OptumHealth Admit dates 1/1/14-12/31/15: Submit to ValueOptions Admit dates 1/1/16 and after: Submit to Beacon Health Options (formerly ValueOptions)	February 2021 Call 1-877-769-7447 and select the correct mental health substance abuse carrier from the menu.
Nutritional Counseling			
		Submit to UnitedHealthcare	
Outpatient Diagnostic Testing/Procedures			
Therapeutic Cardioversion	Submit to Empire		If billed in association with a coverable service (i.e. accidental injury or medical emergency)
Allergy Testing		Submit to UnitedHealthcare	If billed alone
Surgery in Outpatient Hospital			
Hospital	Submit to Empire		
Physician		Submit to UnitedHealthcare	
Surgery in a Freestanding Ambulatory Surgery Center (ASC)			
Freestanding ASC not owned by a hospital		Submit to UnitedHealthcare	
Freestanding ASC owned and billed by a hospital	Submit to Empire		
Professional charges associated with the surgery		Submit to UnitedHealthcare	
Pharmacy			
Outpatient	Submit to Empire		Must be billed with a coverable service (i.e. accidental injury, medical emergency).
Inpatient	Submit to Empire		
Physical Therapy			
Outpatient department of the hospital	Submit to Empire		Services must be provided at the hospital and meet specific Empire Plan qualifying claim criteria. The member must be physically present in the outpatient department of the hospital. Final determination that a claim qualifies for benefits will be made by Empire.

Provided outside of the hospital or doesn't meet the criteria for hospital benefits		Submit to UnitedHealthcare	Managed by Managed Physical Medicine. January 2021 Network. Contact UHC. Precertification is required.
Preadmission Testing			
	Submit to Empire		Some radiology services require precertification.
In the event that a scheduled surgery is cancelled	Submit to Empire		Services may default to diagnostic testing. Subject to applicable copayment. Some radiology services require precertification (see Radiology).
Radiation Therapy			
Hospital	Submit to Empire		Patient must be physically present at the hospital.
Physician		Submit to UnitedHealthcare	
Radiology			
Screening Mammograms in hospital setting.	Submit to Empire		No precertification is required.
Diagnostic Mammograms in hospital setting.	Submit to Empire		No precertification is required.
Other Radiology Services (CT, PET, MRI, MRA, Nuclear Radiology):	Submit to Empire		<p>Patient must be physically present at the hospital and services must be rendered in an affiliated hospital setting or location.</p> <p>Precertification is required for all elective radiology procedures (CT, PET, MRI, MRA, Nuclear Radiology).</p> <p>No precertification is required for emergency radiology procedures.</p>
Hospital (OP) diagnostic radiology not listed above.	Submit to Empire		
Hospital (OP) routine radiology not listed above.		Submit to UnitedHealthcare	
Skilled Nursing Facility			
Hospital	Submit to Empire		Precertification is required through Empire. SNF is not covered if Medicare is primary.
Physician		Submit to UnitedHealthcare	
Transplants			
Centers of Excellence for Transplants with Blue Quality Centers for Transplants (BQCT)	Submit to Empire		Hospitals must be participating with the BQCT Program for member to be eligible for enhanced benefits.
Bone Marrow Peripheral Stem Cell Cord Blood Stem Cell Heart	Submit to Empire		<p>Includes:</p> <ol style="list-style-type: none"> 1. Pre-transplant evaluation and re-evaluation.

Heart-Lung Kidney Liver Lung Simultaneous Kidney-Pancreas			<p>2. IP and OP hospital and physician care related to the transplant, including 12 months of follow-up care at the Center of Excellence where the transplant was performed.</p> <p>Contact the Centers of Excellence for Transplants Program at Empire to determine the patient's eligibility for the above enhanced benefits.</p>
For NON-Blue Quality Center for Transplant Providers: Hospital Physician	<p>Submit to Empire Submit to UnitedHealthcare</p>		
Wound Care			
If surgical debridement is performed	Submit to Empire		
If no surgical debridement is performed		Submit to UnitedHealthcare	

Online Provider Directories and Demographic Data Integrity

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

Online Provider Directory

Providers and Facilities who have questions on their participation status are encouraged to contact Provider Services at 1-800-992-BLUE (2583).

Accessing the Online Provider Directory:

- Go to empireblue.com/provider
- Select the [Find a Doctor](#) link at the top right of the page.
- To search our online Provider Directory either enter your member information or enter as guest.

If you are directing a Member to another Provider or Facility, please verify that the Provider or Facility is participating in the Member's specific network.

- To help ensure you are directing a Member to stay within his/her specific Network, utilize the Online Provider Directory one of the following ways:
 - **Search as a Member:** Search by entering the Member's ID number (including the three-character prefix), or simply enter the three-character prefix by itself.
 - **Search as a Guest:** Search by Selecting a Plan or Network. Note: You can usually find the Member's Network Name on the lower right corner of the front of the Member's ID card.

Updating your Demographic Data with Empire

It is critical that your patients receive accurate and current data related to provider availability. Please notify Empire of any changes to your Provider and Facility information. All requests must be received 30 days prior to change/update. Any requests received within less than 30 days' notice may be assigned a future effective date. Contractual terms may supersede effective date request.

Notes:

- Tax ID changes must be accompanied by a W-9 to be valid.
- For notices of termination from our network, refer to the termination clause in your Agreement for specific notification requirements. Please allow 60 days' notice of termination from our network as required by your Agreement.

Types of demographic data updates can include, but are not limited to:

- Accepting New Patients
- Address – Additions, Terminations, Updates (including physical and billing locations)
- Areas of Expertise (Behavioral Health Only)
- Email Address
- Handicapped Accessibility
- Hospital Affiliation and Admitting Privileges
- Languages Spoken

- License Number
- Name change (Provider/Organization or Practice)
- National Provider Identifier (NPI)
- Network Participation
- Office Hours/Days of Operation
- Patient Age/Gender Preference
- Phone/Fax Number
- Provider Leaving Group, Retiring, or Joining another Practice*
- Specialty
- Tax Identification Number (TIN)
- Termination of Provider Participation Agreement
- Web Address

Please send us this information in one of the following ways:

- Online form: www.Availity.com/Payer Spaces/Empire BlueCross or Empire BlueCross BlueShield/Resources/Empire BlueCross BlueShield Maintenance Form.
- Fax Number: 1-855-325-5456
- Address: Empire BlueCross BlueShield
ATTN: Provider Data Consumption,
1155 Elm Street, Suite 200
Manchester, NH 03101-1505

Demographic Updates / Changes

Verification Process

Empire is **required by the State of New York** to ensure that we are publishing accurate directory information for our members in both our on-line and paper provider directories. However, this information is only as good as what is provided by you, our physicians and practitioners. Empire conducts quarterly verifications of its demographic and participation information and you may be receiving a fax, phone call, or letter requesting that this information be confirmed. A non-response will result in your practice confirming there are no changes and your information will continue to appear as a participating provider in either our online Provider Finder or our printed directories for all lines of business.

Empire and its affiliates may use, publish, disclose, and display information and disclaimers, as applicable, relating to you and your information. Physician based communications and publications need to be approved by Empire for content prior to its release if the communication or publication will be using Empire's name and branding to communicate to the physicians' membership.

Empire will be performing outreach for verification of demographic information quarterly to ensure that your information is displayed appropriately in Empire's Provider and Facility Directories.

Availity Portal

Empire is offering an array of online tools through the Availity Portal, a secure multi-health plan portal.

Engage and obtain information needed with the following tools:

- **Claim Submission** – Submit a single, electronic Claim.
- **Claim Status Inquiry** – See details and payment information including Claim line-level details/processing.
- **Interactive Care Reviewer** – Secure, online provider authorization, referral and inquiry tool for many Empire Members.
 - AIM Specialty Health-access link to precertification requests and inquiries for specific services and access the **OptiNet® Survey when applicable**.
- **Medical Attachments** – Submit medical records electronically when requested by the Health Plan. Includes the ability to submit an itemized bill electronically. **Member Certificate Booklet** – View a local plan Member’s certificate of coverage, when available
- **Member eligibility and benefits inquiry** – Get real-time patient eligibility, benefits, and accumulative data, including current and historical coverage information, plus detailed co-insurance, co-payment and deductible information for ALL Members, including BlueCard® and FEP®.
 - **Member ID Card Viewer** – View the front and back of a Member’s ID card when available.
 - **Secure Messaging** – Send a question to clarify the status of a claim or to get additional information on Claims where applicable

Payer Spaces:

View Empire specific tools by selecting **Payer Spaces**, then the **Empire icon** to view the following tools:

- **Clear Claim Connection** – Research procedure code edits and receive edit rationale.
- **Custom Learning Center** – Access payer-centric training and educational videos.
- **Education and Reference Center** – Locate important policies, forms and educational resources.
- **Fee Schedule** – Retrieves professional office-based standard price information for patient services performed.
- **Remittance Inquiry** – View an imaged copy of the paper Empire remits up to 15 months in the past.
- **Patient360** – Real time, robust picture of patient’s health and treatment history, including gaps in care and care remembers.
- **Plus**, links to other Empire pages, tool overview documents and more:

Take advantage of these Availity benefits

- **No charge** – Empire transactions are available at no charge to providers.
- **Accessibility** – Availity functions are available 24 hours a day from any computer with Internet access.
- **Standard responses** – Responses from multiple payers returned in the same format and screen layout, providing users with a consistent look and feel.
- **Access to both commercial and government payers** – Users can access data from Empire, Medicare, Medicaid and other commercial insurers (See www.availity.com for a full list of payers.)
- **Compliance** – Availity is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

How to get started

To register for access to Availity, go to <https://www.availity.com/provider-portal-registration>. It's that simple! For additional assistance in getting registered, please contact Availity Client Services at 1-800-AVAILITY (282-4548).

If you need further assistance getting registered, please contact Availity Client Services at 1-800-AVAILITY (282-4548).

Availity Training

After logging into Availity, Providers and Facilities have access to many resources to help jumpstart learning, including free and on-demand training, frequently asked questions, comprehensive help topics and other resources to help ensure Providers and Facilities get the most out of the Availity experience. Availity also offers onboarding modules for new Administrators and Users.

For more information on navigating in Availity, select **Help & Training** (from the top navigation menu on the Availity home page) | **Get Trained**, and type “*onboarding*” in the search catalog field. Or, go to **Help & Training | My Learning Plan**, and plot your learning journey

Availity Training for Empire specific tools

For more information on Empire features and navigation, select **Payer Spaces | Applications | Education and Reference Center** to find presentations and reference guides that can be used to educate provider staff on Empire proprietary tools.

Organization Maintenance

To change/update an Administrator or Organization information:

- To replace the Administrator currently on record with Availity, please call Availity Client Services at 1-800-AVAILITY (282-4548).
- An Administrator can use the *Maintain Organization* feature to maintain the organization's demographic information, including address, phone number, tax ID, and NPI. Any changes made to this information automatically apply to all Users associated to the organization and affects only the registration information on the Availity Portal.

Eligibility and Member ID card Samples

Alpha Prefix Information

The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route out-of-area claims. The alpha prefix identifies the BCBS Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage.

Some identification cards with a BlueCard suitcase may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard program. Please look for instructions or a telephone number on the back of the card for information on how to file these claims. If that information is not available, call the Eligibility Line at 1-800-713-4173, 8:30 a.m. to 5:00 p.m. EST, Monday – Friday.

Occasionally, you may see identification cards from foreign BCBS Plan members. These identification cards will also contain three-character alpha prefixes. Please treat these members the same as domestic BCBS Plan members.

Suitcase Logos

To provide the visual symbol that physicians and facilities need to identify PPO members, ID cards with the PPO logo for those members who have BlueCard PPO or BlueCard EPO benefits have been created. The logo, shown below, must appear on the face of the card. A “PPO” in a suitcase logo means that the patient has a PPO program.







Remember: Not all PPO members are BlueCard PPO members, only those whose membership cards carry this logo are part of the BlueCard PPO Plan.

To identify all other BlueCard members, with the exception of those with Medigap coverage, that do not have BlueCard PPO, the blank (empty) suitcase logo is included on the face of the card. The blank suitcase, in conjunction with the alpha prefix, will communicate to providers how to process member claims. A blank suitcase logo on a member's identification card means that the patient has a Traditional (Indemnity), POS, or HMO product.







ID card Samples




Direct HMO ID card

 An Anthem Company FIRSTNAME LASTNAME Identification Number YLL88888888 Group: 123456 DHM Relationship Code: 00 Health Plan: DIRECT HMO BS Plan 803 BC Plan 303  R	Rx Co-pay: \$10/\$35/\$70 RX BIN#PCN: 003858/A4 Rx Group: WLDA Office Visit Co-pay: \$20 ER Co-pay: \$75  X85951263700001	 An Anthem Company www.empireblue.com Member Services BlueCard Access Inpatient Mental Health Substance Abuse and Outpatient Mental Health 24/7 Nurseline Please be sure to call Member and Provider Services for Benefits, Claims, and Provider questions, before receiving services requiring precertification and within 48 hours of an emergency admission. These services are described in your benefit literature. Call 24/7 Nurseline to access prerecorded health topics or to speak with an RN 24/7. Providers submit all claims to your local Blue Cross and/or Blue Shield Plan, or if Medicare is primary submit Medicare claims to Medicare. In California, send claims to: Claims P.O. Box 60007 Los Angeles, CA 90060-0007 4969 Print Date: 09/08/2015	1-844-866-3694 1-800-810-BLUE 1-844-866-3694 1-212-237-3037 1-877-TALK-2-RN Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield Plans. Empire HealthChoice Assurance, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
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Direct Share POS ID card

 An Anthem Company FIRSTNAME LASTNAME Identification Number YLL88888888 Group: 123456 DHM Relationship Code: 00 Health Plan: DIRECT HMO BS Plan 803 BC Plan 303  R	Rx Co-pay: \$10/\$35/\$70 RX BIN#PCN: 003858/A4 Rx Group: WLDA Office Visit Co-pay: \$20 ER Co-pay: \$75  X85951263700001	 An Anthem Company www.empireblue.com Member Services BlueCard Access Inpatient Mental Health Substance Abuse and Outpatient Mental Health 24/7 Nurseline Please be sure to call Member and Provider Services for Benefits, Claims, and Provider questions, before receiving services requiring precertification and within 48 hours of an emergency admission. These services are described in your benefit literature. Call 24/7 Nurseline to access prerecorded health topics or to speak with an RN 24/7. Providers submit all claims to your local Blue Cross and/or Blue Shield Plan, or if Medicare is primary submit Medicare claims to Medicare. In California, send claims to: Claims P.O. Box 60007 Los Angeles, CA 90060-0007 4969 Print Date: 09/08/2015	1-844-866-3694 1-800-810-BLUE 1-844-866-3694 1-212-237-3037 1-877-TALK-2-RN Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield Plans. Empire HealthChoice Assurance, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
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EPO ID card

 An Anthem Company	
FIRSTNAME LASTNAME Identification Number YLK88954601	Rx Co-pay: \$10/25/60 RX BIN#/PCN: 003858/A4 Rx Group: WLDA
Group: 123456 EPO Relationship Code: 00 Health Plan: EPO BS Plan 803 BC Plan 303	Office Visit Co-pay: \$20 ER Co-pay: \$150
<div style="text-align: right;">   </div>	


X85957466000001

 An Anthem Company		www.empireblue.com
Please be sure to call Member and Provider Services for Benefits, Claims, and Provider questions, before receiving services requiring precertification and within 48 hours of an emergency admission. These services are described in your benefit literature.		Member Services BlueCard Access Inpatient Mental Health Substance Abuse and Outpatient Mental Health 24/7 Nurseline 1-844-866-3694 1-800-810-BLUE 1-844-866-3694 1-212-237-3037 1-877-TALK-2-RN
Call 24/7 Nurseline to access prerecorded health topics or to speak with an RN 24/7. Providers submit all claims to your local Blue Cross and/or Blue Shield Plan; or if Medicare is primary submit Medicare claims to Medicare. In California, send claims to: Claims P.O. Box 60007 Los Angeles, CA 90060-0007		Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Empire HealthChoice Assurance, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
4969		Print Date: 09/08/2015




PPO ID card

 An Anthem Company	
FIRSTNAME LASTNAME Identification Number YLD88954600	Rx Co-pay: \$10/20/50 RX BIN#/PCN: 003858/A4 Rx Group: WLDA
Group: 123456 PPO Relationship Code: 00 Health Plan: PPO BS Plan 803 BC Plan 303	Primary Care Co-pay: \$20 Specialist Co-pay: \$30 ER Co-pay: \$100 In-Network Deductible: \$250/500 In-Network Preventive Care: \$0
<div style="text-align: right;">   </div>	


X85980941900001

 An Anthem Company		www.empireblue.com/hotelfunds
In order to avoid a reduction in benefits, please be sure to call Member and Provider Services for precertification, benefit, claims and provider questions, before receiving services requiring precertification or within 2 business days of an emergency admission. These services are described in your benefit literature. The above does not apply if Medicare is primary.		Member Services BlueCard Access Inpatient Mental Health Substance Abuse and Outpatient Mental Health 24/7 Nurseline 1-844-866-3694 1-800-810-BLUE 1-844-866-3694 1-212-237-3037 1-877-TALK-2-RN
Providers submit all claims to your local Blue Cross and/or Blue Shield Plan; or if Medicare is primary submit Medicare claims to Medicare. In California, send claims to: Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007		Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Empire HealthChoice Assurance, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
4969		Print Date: 09/08/2015

Empire Total Blue ID card

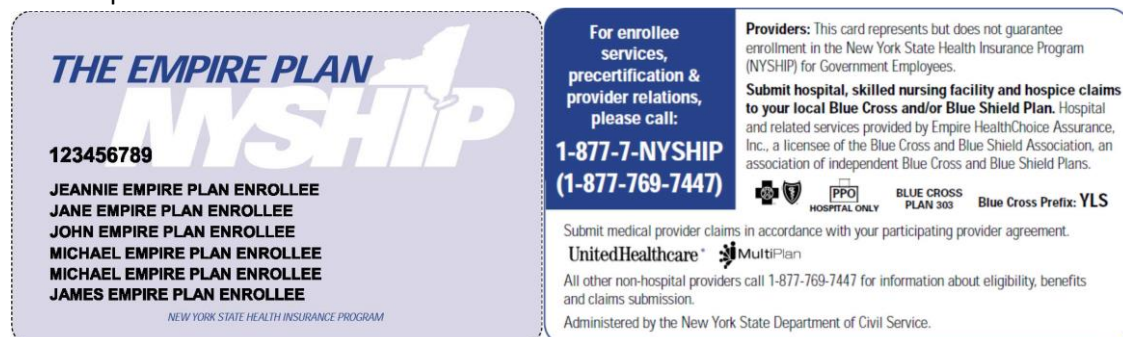
 An Anthem Company	
FIRST LAST Identification Number YLD88954602	RX BIN#/PCN: 003858/A4 Rx Group: WLDA
Group: 123456 BLU Relationship Code: 00 Health Plan: TOTAL BLUE(SM) CHOICE Funding Account: RSA BS Plan 803 BC Plan 303	In-Network Preventive Care: \$0
<div style="text-align: right;">   </div>	

X85954753400001

 An Anthem Company		www.empireblue.com
Please be sure to call Member and Provider Services for Benefits, Claims, and Provider questions, before receiving services requiring precertification and within 48 hours of an emergency admission. These services are described in your benefit literature.		Member Services BlueCard Access Inpatient Mental Health Substance Abuse and Outpatient Mental Health 24/7 Nurseline 1-844-866-3694 1-800-810-BLUE 1-844-866-3694 1-212-237-3037 1-877-TALK-2-RN
Call 24/7 Nurseline to access prerecorded health topics or to speak with an RN 24/7. Providers submit all claims to your local Blue Cross and/or Blue Shield Plan; or if Medicare is primary submit Medicare claims to Medicare. In California, send claims to: Claims P.O. Box 60007 Los Angeles, CA 90060-0007		Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Empire HealthChoice Assurance, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
4969		Print Date: 09/08/2015

New York State Members

Please note that the members' actual co-payment amounts may be different than what is displayed on this sample card.



New York City Members

Please note that the members' actual co-payment amounts may be different than what is displayed on this sample card.



Newborn Enrollment

According to the NY Insurance law for Empire's fully insured members, it must pay for inpatient care for a newborn's first 48 hours (vaginal delivery) or 96 hours (c-section delivery), without regard to whether the newborn has been enrolled under the insured benefit plan.

Please note: If a self-funded benefit plan has not elected to follow the NY newborn mandate, the newborn must be separately enrolled as a dependent under the self-funded benefit plan within the time frame specified by the plan in order to obtain coverage, including the inpatient care of the newborn's first 48 hours (vaginal delivery) or 96 hours (c-section delivery). If the newborn is not enrolled within the time frame specified by the self-funded benefit plan, the claim will be denied.

The following provides additional guidance on Empire's insured benefit plans:

- For coverage beyond the initial inpatient nursery care, all newborn children must be enrolled as dependents within 30 or 60 days of birth, as required by the plan, in order to ensure coverage with no claims processing delays.
- **Members with Individual, Employee/Spouse or Parent/Child contracts** must submit an

Enrollment/Change form to add a newborn, and change their plans to Parent/Child, Parent/Children or Family coverage (and pay the premium) 30 or 60 days, as required by the plan, after the date of the baby's birth for coverage to be retroactive to the date of birth. **Claims submitted before the newborn is enrolled under the correct contract type will be denied. These claims will be reprocessed once the newborn is enrolled at the normal newborn allowance, as long as it is within 30 or 60 days of the birth, as required by the plan.**

- If Empire does not receive the Enrollment/Change form within 30 or 60 days, as required by the plan, after the baby's birth, coverage will begin on the actual date we receive the completed form, as long as we receive it during the next open enrollment period after the birth, or during the first year after the birth, whichever occurs first.
- **Members with Family or Parent/Children contracts** have coverage for newborn children but **MUST** submit an Enrollment/Change form to add the newborn to the benefit contract. Coverage is effective from the newborn's date of birth provided that the newborn is enrolled.

For Enrollment through Employer Online Services

When the contract types are Individual, Employee/Spouse or Parent/Child and the Group Benefits Administrator (GBA) logs on to add the newborn after 30 or 60 days, as required by the plan, from the date of birth, the GBA may select either the current date (at which the GBA logged on) or the date of Open Enrollment as the effective date of coverage for the newborn.

Claims Submission

Claim Submission Filing Tips

Eliminate processing delays and unnecessary correspondence with these Claim filing tips:

CPT Coding

The current version of the CPT® Professional Edition manual is considered by Empire as the industry standard for accurate CPT and modifier coding.

Electronic Claims Submissions

Please submit Claims electronically whenever possible. If Providers or Facilities have questions about electronic submissions, or if Providers or Facilities want to learn more about how EDI can work for Providers or Facilities, please review the EDI Submissions section in this manual or call 1-800-470-9630.

Please refer to the subsection titled [Recommended Fields for Electronic 837 Professional \(837P\) and Institutional \(837I\) Health Care Claims](#) for more information on EDI submissions.

Paper Claims Submissions

If Providers or Facilities must file Claims on paper, failure to submit them on the most current CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04) will cause Claims to be rejected and returned to the Provider or Facility. More information and the most current forms can be found at www.cms.gov.

- Submit all paper Claims using the current standard RED CMS Form 1500 (02-12) for professional Claims and the UB-04 (CMS-1450) for Facility Claims.
- If Providers or Facilities are submitting a multiple page Claim, the word "continued" should be noted in the total charge field, with the total charge submitted on the last page of the Claim.

- When submitting a multiple page document, do not staple over pertinent information.
- Complete all mandatory fields.
- Do not highlight any fields.
- Check the printing of Claims from time to time to help ensure proper alignment and that characters are legible.
- Ensure all characters are inside the appropriate fields and do not overlap.
- Change the printer cartridge regularly and do not use a DOT matrix printer.
- Submit a valid member identification number including three digit prefix or R+8 numeric for Federal Employee Program® (FEP®) members on all pages.
- Claims must be submitted with complete provider information, including referring, rendering and billing NPI; tax identification number; name; and servicing and billing addresses on all pages.

Please refer to the subsection titled [Recommended Fields for Paper CMS Form 1500 \(02-12\) and UB-04 \(CMS-1450\) Claims](#) for more information on paper submissions.

Ambulatory Surgical Centers

When billing revenue codes, always include the CPT or HCPCS code for the surgery being performed. This code is required to determine the procedure, and including it on the Claim helps us process the Claim correctly and more quickly. Ambulatory surgical Claims must be billed on a CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04), as indicated in your Agreement.

Ancillary Filing Guidelines

Ambulance Claims

- Include the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) Claims, both institutional outpatient and professional.
- File the Claims to the plan whose service area the Point of Pickup (POP) ZIP Code is located.
- The POP (Point of Pick-up) ZIP Code should be submitted as follows:
 - *Professional Claims* – for CMS-1500 submitters: the POP ZIP code is reported in field 23
 - *Institutional outpatient Claims* – for UB submitters: the Value Code of ‘A0’ (zero), and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance, should be reported in the Value Code Amount field and billed with the appropriate revenue 54x codes.

Durable/Home Medical Equipment and Supplies

- Durable/Home Medical Equipment and Supplies (D/HME) is determined by the provider specialty code in the provider file, not by CPT codes.
- **Delivered to patient’s home** – File the Claim to the plan in the service area where the item was sent/delivered.
- **Purchased at retail store** – File the Claim to the plan in the service area where the retail store is located.

Home Infusion Therapy - Services and Supplies

- File the Claim with the plan in the service area where the services are rendered or the supply was delivered. Examples: If services are rendered in a member’s home, Claims should be sent to the plan in the member’s state. If Supplies are delivered to the member’s home, Claims should be sent to the plan in the member’s state.

Laboratory Claims

- File the Claim to the plan in the service area where the specimen was drawn, as determined by the referring provider's location (based on NPI)
- Independent lab Claims are determined by the provider specialty code in the provider file, not by CPT codes.
- Unless exempted by state or other legal guidelines, Anthem requires the CLIA number to be included on each Claim billed for laboratory services by any Provider or Facility performing tests covered by CLIA. Anthem requires the CLIA identification number to be submitted based on the applicable method below:
 - ASC X12 837 professional claim format REF segment as REF02, with qualifier of "X4" in REF01 or
 - Field 23 of the paper CMS-1500
-

Specialty Pharmacy Claims

- File the Claim to the plan in the service area where the referring provider is located (based on NPI).
- Specialty pharmacy Claims are determined by the provider specialty code in the provider file, not by CPT codes.

Duplicate Claims (aka Tracers)

Providers and Facilities should refrain from submitting a Claim multiple times to avoid potential duplicate denials. Providers or Facilities can check the status of Claims via Availity.

Late Charges

Late charges for Claims previously filed can be submitted electronically. You must reference the original Claim number in the re-billed electronic Claim. If attachments are required, please submit them using the PWK attachment face sheet. (See Electronic Data Interchange website for instructions as www.Empireblue.com/edi).

Late charges for Claims previously filed can be submitted via paper. Type of bill should contain a 5 in the 3rd position of the TOB (ex: 135). A late billing should contain ONLY the additional late charges. The Provider should also advise the original claim# to which the late charges should be added.

Maternity Delivery Claims

Delivery procedure codes reported on a professional Claim (procedure codes: 59612, 59620, 59400, 59410, 59515, 59614, 59622, 59510, 59610, or 59618) are required to submit with the appropriate Z3A diagnosis code indicating the babies gestational age.

National Drug Codes (NDC)

See separate subsection titled *National Drug Codes*.

Negative Charges

When filing Claims for procedures with negative charges, please don't include these lines on the Claim. Negative charges often result in an out-of-balance Claim that must be returned to the provider for additional clarification.

Not Otherwise Classified (“NOC”) Codes

- When submitting Not Otherwise Classified (NOC) codes please follow these guidelines to avoid possible Claim processing delays. **Empire must have a clear description of the item/service billed with a NOC code for review.**
 - If the NOC is for a drug, include the drug’s name, dosage NDC number and number of units.
 - If the NOC is not a drug, include a specific description of the procedure, service or item.
 - If the item is durable medical equipment, include the manufacture’s description, model number and purchase price if rental equipment.
 - If the service is a medical or surgical procedure, include a description on the Claim and submit medical record/and the operative report (if surgical) that support the use of an NOC and medical necessity for the procedure.
 - If the NOC is for a laboratory test, include the specific name of the laboratory test(s) and/or a short descriptor of the test(s)

NOTE: NOC codes should only be used if there are no appropriate listed codes available for the item or service. Descriptions should be included in the shaded area for item 24 on professional Claim forms, or locator 43 on facility Claim forms.

Occurrence Dates

When billing facility Claims, please make sure the surgery date is within the service from and to dates on the Claim. Claims that include a surgical procedure date that falls outside the service from and to dates will be returned to the provider.

Other Insurance Coverage

When filing Claims with other insurance coverage, please ensure the following fields are completed and that a legible copy of the Explanation of Benefits (EOB) from the other insurance coverage is attached to the Claim:

CMS-1500 Fields:

Field 9: Other insured’s name

Field 9a: Other insured’s policy or group number

Field 9b: Other insured’s date of birth

Field 9c: Employer’s name or school name (not required in EDI)

Field 9d: Insurance plan name or program name (not required in EDI)

UB-04 CMS-1450 Fields:

Field 50a-c: Payer Name

Field 54a-c: Prior payments (if applicable)

Including Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB):

When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) Claim form with an Explanation of Medicare Benefits (EOMB) attached, the EOMB should indicate Medicare’s Assignment. When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) Claim form with an Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB) attached, the EOMB or EOB should match each service line and each service line charge submitted on the CMS Form 1500 (02-12) or CMS-1450 (UB04).

Preventive Colonoscopy – correct coding

Empire allows for preventive colonoscopy in accordance with state mandates. Colonoscopies which are undertaken as a SCREENING colonoscopy, during which a polyp/tumor or other procedure due to an abnormality are discovered, should be covered under benefits for Preventive Services. This has been an area of much confusion in billing by Providers or Facilities of services. Frequently the Provider or Facility will bill for the CPT code with an ICD-10 diagnosis code corresponding to the pathology found rather than the “Special screening for malignant neoplasms, of the colon”, diagnosis code V76.51.

CMS has issued guidance on correct coding for this situation and states that the *ICD-10 diagnosis code Z12.11 (Encounter for screening for malignant neoplasm of colon) should be entered as the primary diagnosis* and that the ICD-10 diagnosis code for any discovered pathology should be entered as the secondary diagnosis on all subsequent Claim lines.

Empire endorses this solution for this coding issue as the appropriate method of coding to ensure that the Provider or Facility receives the correct reimbursement for services rendered and that our members receive the correct benefit coverage for this important service.

Type of Billing Codes

When billing facility Claims, please make sure the type of bill coincides with the revenue code(s) billed on the Claim. For example, if billing an outpatient revenue code, the type of bill must be for outpatient services.

Claim Inquiry/Adjustment Filing Tips

The different types of Claim inquiries should be handled in separate ways depending on what is being requested. Here are some examples:

- Claim Inquiry: A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can send a Secure Message through the Availity Portal, or call the Provider Services number on the back of the Member ID Card and select the *Claims* prompt. Please reference the *Availity Portal* section for further details on Secure Messaging.
- Claim Correspondence: Claim Correspondence is when Empire requires more information to finalize a Claim. Typically, Empire makes the request for this information through the Explanation of Payment (“EOP”) The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Empire will use it to finalize the Claim.
- Clinical / Medical Necessity Appeals: An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals, please refer to the *Clinical Appeals* section within the Provider Manual.
- Claim Payment Disputes: Please see the *Claim Payment Dispute* section for further details.
- Precertification Disputes: Precertification disputes should be handled via the process detailed in the letter received from our precertification department. If Providers or Facilities disagree with a clinical decision, please follow the directions detailed on our letter. Sending

precertification/predetermination requests or appeals to the provider correspondence address may delay responses.

- **Corrected Claims:** Submitting corrected Claims should only be utilized to update information on the Claim form. If the inquiry is about the way the Claim processed, please refer to the prior sections. If Providers or Facilities have corrections to be made to the Claim, please submit according to the Corrected Claim Guidance below.

Timely Filing for Claims

Claims must be submitted within the timely filing timeframe specified in your contract.

All additional information reasonably required by Anthem to verify and confirm the services and charges must be provided on request.

Claims submitted after the timely filing period expires will be denied, unless proof of timely filing can be demonstrated according to the guideline listed below.

Proof of Timely Filing

Waiver of the timely filing requirement is only permitted when Anthem has received documentation indicating the Member, Provider or Facility originally submitted the claim within the applicable timely filing period.

The documentation submitted **must** indicate the Claim was originally submitted before the timely filing period expired.

Acceptable documentation includes the following:

1. A copy of the Claim with a **computer-printed filing date** (a handwritten date isn't acceptable)
2. An original fax confirmation specifying the Claim in question and including the following information: date of service, amount billed, Member name, original date filed with Anthem and description of the service
3. The Provider or Facility's billing system printout showing the following information: date of service, amount billed, Member name, original date filed with Anthem and description of the service

If the Provider or Facility doesn't have an electronic billing system, approved documentation is a copy of the Member's chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.

4. If the Claim was originally filed electronically, a copy of Anthem's electronic Level 2 or your respective clearinghouse's acceptance/rejection claims report is required; a copy can be obtained from the Provider or Facility's EDI vendor, EDI representative or clearinghouse representative. The Provider or Facility also must demonstrate that the Claim and the Member's name are on the original acceptance/rejection report. Note: When referencing the acceptance/reject report, the Claim must show as accepted to qualify for proof of timely filing. Any rejected Claims must be corrected and resubmitted within the timely filing period.

5. A copy of the Anthem letter requesting additional Claim information showing the date information was requested.

Appeals for Claims denied for failing to meet timely filing requirements must be submitted to Anthem **in writing**. Anthem doesn't accept appeals over the phone.

Corrected Claim Guidance

When submitting a correction to a previously submitted Claim, submit the entire Claim as a replacement Claim if Providers or Facilities have omitted charges or changed Claim information (i.e., diagnosis codes, procedure codes, dates of service, etc.) including all previous information and any corrected or additional information. To correct a Claim that was billed to Empire in error, submit the entire Claim as a void/cancel of prior Claim.

Type	Professional Claim	Institutional Claim
EDI	To indicate the Claim is a replacement Claim: <ul style="list-style-type: none"> In element CLM05-3 "Claim Frequency Type Code" Use Claim Frequency Type 7 	To indicate the Claim is a replacement Claim: <ul style="list-style-type: none"> In element CLM05-3 "Claim Frequency Type Code" Use Claim Frequency Type 7
	To confirm the Claim which is being replaced: <ul style="list-style-type: none"> In Segment "REF – Payer Claim Control Number" Use F8 in REF)! and list the original payer Claim number is REF02 	To confirm the Claim which is being replaced: <ul style="list-style-type: none"> In Segment "REF – Payer Claim Control Number" Use F8 in REF)! and list the original payer Claim number is REF02
	To indicate the Claim was billed in error (Void/Cancel): <ul style="list-style-type: none"> In element CLM05-3 "Claim Frequency Type Code" Use Claim Frequency Type 8 	To indicate the Claim was billed in error (Void/Cancel): <ul style="list-style-type: none"> In element CLM05-3 "Claim Frequency Type Code" Use Claim Frequency Type 8
	To confirm the Claim which is being void/cancelled: <ul style="list-style-type: none"> In Segment "REF – Payer Claim Control Number" Use F8 in REF)! and list the original payer Claim number is REF02 	To confirm the Claim which is being void/cancelled: <ul style="list-style-type: none"> In Segment "REF – Payer Claim Control Number" Use F8 in REF)! and list the original payer Claim number is REF02
Paper	To indicate the Claim is a replacement Claim: <ul style="list-style-type: none"> In Item Number 22: "Resubmission and/or Original Reference Number" Use Claim Frequency Type 7 under "Resubmission Code" 	To indicate the Claim is a replacement Claim: <ul style="list-style-type: none"> In Form Locator 04: "Type of Bill" Use Claim Frequency Type 7
	To confirm the Claim which is being replaced:	To confirm the Claim which is being replaced:

Type	Professional Claim	Institutional Claim
	<ul style="list-style-type: none"> In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the resubmitted Claim. 	<ul style="list-style-type: none"> In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the resubmitted Claim.
	To indicate the Claim is a void/cancel of a prior Claim: <ul style="list-style-type: none"> In Item Number 22: "Resubmission and/or Original Reference Number" Use Claim Frequency Type 8 under "Resubmission Code" 	To indicate the Claim is a void/cancel of a prior Claim: <ul style="list-style-type: none"> In Form Locator 04: "Type of Bill" Use Claim Frequency Type 8
	To confirm the Claim which is being void/cancelled: <ul style="list-style-type: none"> In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the void/cancelled Claim. 	To confirm the Claim which is being void/cancelled: <ul style="list-style-type: none"> In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the void/cancelled Claim.

For additional information on provider complaints and appeals, please refer to the *Claim Payment Dispute* and Appeals sections.

National Drug Codes (NDC)

All practitioners and providers are required to supply the 11-digit NDC when billing for injections and other drug items on the CMS1500 and UB04 Claim forms as well as on the 837 electronic transactions. *Note: These billing requirements will apply to Local Plan and BlueCard member Claims only, and will exclude Federal Employee Program (FEP) and Coordination of Benefits/ Secondary Claims.*

Line items on a claim regarding drugs administered in a physician office or outpatient facility setting for all drug categories will deny if they do not include the following:

- Applicable HCPCS code or CPT code
- Number of HCPCS code or CPT code units
- The valid 11-digit NDC, including the N4 qualifier
- Unit of measure qualifier (F2, GR, ML, UN, MG)
- NDC Units dispensed (must be greater than 0)

Unit of Measurement Requirements

The unit of measurement codes are also required to be submitted. The codes to be used for all Claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN – Unit
- MG - Milligram

Location of the NDC

The NDC is found on the label of a prescription drug item and must be included on the CMS-1500 or UB04 Claim form or in 837 electronic transactions. The NDC is a universal number that identifies a drug or related drug item.



NDC Number Section	Description
1 (five digits)	Vendor/distributor identification
2 (four digits)	Generic entity, strength and dosage information
3 (two digits)	Package code indicating the package size

Correcting Omission of a Leading Zero

Providers and Facilities may encounter NDCs with fewer than 11-digits. In order to submit a Claim, Providers and Facilities will need to convert the NDC to an 11-digit number. Sometimes the NDC is printed on a drug item and a leading zero has been omitted in one of the segments. Instead of the digits and hyphens being in a 5-4-2 format, the NDC might be printed in a 4-4-1 format (example, 1234-1234-1), a 5-3-2 format (example, 12345-123-12), or a 5-4-1 format (example, 12345-1234-1).

- If this occurs, when entering the NDC on the Claim form, it will be required to add a leading zero to the beginning of the segment(s) that is missing the zero.
- Do not enter any of the hyphens on Claim forms.

See the examples that follow:

If the NDC appears as...	Then the NDC...	And it is reported as ...
NDC 12345-1234-12 (5-4-2 format)	Is complete	12345123412
NDC 1234-1234-1 (4-4-1 format)	Needs a leading zero placed at the beginning of the first segment and the last segment	01234123401
NDC 12345-123-12 (5-3-2 format)	Needs a leading zero placed at the beginning of the second segment	12345012312

NDC 12345-1234-1 (5-4-1 format)	Needs a leading zero placed at the beginning of the third segment	12345123401
------------------------------------	---	-------------

Process for Multiple NDC numbers for Single HCPC Codes

- If there is more than one NDC within the HCPCs code, you must submit each applicable NDC as a separate Claim line. Each drug code submitted must have a corresponding NDC on each Claim line.
- If the drug administered is comprised of more than one ingredient (i.e. compound or same drug with different strength, etc.), you must represent each NDC on a Claim line using the same drug code.
- Standard HCPCs billing accepts the use of modifiers to determine when more than one NDC is billed for a service code. They are:
 - KO – Single drug unit dose formulation
 - KP – First drug of a multiple drug unit dose formulation
 - KQ – Second or subsequent drug of a multiple drug unit dose formulation
 - JW – Drug amount discarded /not administered to the patient

How/Where to Place the NDC on a Claim Form

CMS 1500 Claim Form:

- Reporting the NDC requires using the upper **and** lower rows on a Claim line. Be certain to line up information accurately so all characters fall within the proper box and row.
- **DO NOT bill more than one NDC per Claim line.**
- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC you bill does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous code per Correct Coding Guidelines.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a CMS-1500 Claim form.

All Elements are REQUIRED:

How	Example	Where
Enter a valid NDC code including the N4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC in the shaded area of box 24A
Enter one of five (5) units of measure qualifiers; <ul style="list-style-type: none"> • F2 – International Unit • GR – Gram • ML – Milliliter • UN – Units 	GR0.045 ML1.0 UN1.000	In the shaded area immediately following the 11-digit NDC, enter 3 spaces, followed by one of five (5) units of measure qualifiers,

How	Example	Where
<ul style="list-style-type: none"> MG – Milligrams and quantity, including a decimal point for correct reporting		followed immediately by the quantity
Enter a valid HCPCS or CPT code	J0610 “Injection Calcium Gluconate, per 10 ml” is billed as 1 unit for each 10 ml ampul used	Non-shaded area of box 24D

24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS	F. \$ CHARGES	G. DAYS OF UNITS	H. E/P/S/O Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	K. SUPPLIER INFORMATION
MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER	POINT						
1												NPI		
2												NPI		
3												NPI		
4												NPI		
5												NPI		

Enter NDC in shaded area of box 24A

UB04 Claim Form:

- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC you bill does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous code per Correct Coding Guidelines.
- DO NOT bill more than one NDC per Claim line.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a UB04 Claim form.

All Elements are REQUIRED:

How	Example	Where
Enter a valid revenue code	Pharmacy Revenue Code 0252	Form locator (box) 42
Enter 11- digit NDC, including the N4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC In locator (box) 43 currently labeled as “Description”
Enter one of five (5) units of measure qualifiers; <ul style="list-style-type: none"> F2 – International Unit GR - Gram ML - Milliliter UN – Units MG - Milligrams 	GR0.045 ML1.0 UN1.000	Immediately following the 11 digit NDC, enter 3 spaces followed by one of five (5) units of measure qualifiers, followed immediately by the quantity.

and quantity, including a decimal point for correct reporting		
Enter a valid HCPCS or CPT Code	J0610 "injection Calcium, per 10ML" is billed as 1 unit for each 10ML ampul used	Form locator (box 44)

Sample Images of the UB04 Claim Form

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPS CODE	45 SE RV. DATE	46 SE RV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1						0:00	1
2						0:00	2
3						0:00	3
4							4
5							5

Enter NDC
in locator
(box) 43

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPS CODE	45 SE RV. DATE	46 SE RV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
#####	N4##### GR0.045	J####	MMDDYY	1	##.##	0:00	1

837 P And 837 I Reporting Fields

Billing or Software Vendor:

You will need to notify your billing or software vendor that the NDC is to be reported in the following fields in the 837 format:

Tips for Using NDCs When Submitting Electronic Claims

Loop	Segment	Element Name	Information	Sample
2410	LIN02	Product or Service ID Qualifier	Enter product or NDC qualifier N4	LIN**N4*01234567891~
2410	LIN03	Product or Service ID	Enter the NDC	LIN**N4*01234567891~
2410	CTP04	Quantity	Enter quantity billed	CTP****2*UN~
2410	CTP05-1	Unit of Basis for Measurement Code	Enter the NDC unit of measurement code: F2: International unit GR: Gram ML: Milliliter UN: Unit MG: Milligram	CTP****2*UN~

Loop	Segment	Element Name	Information	Sample
2410	REF01	Reference ID Qualifier (used to report Prescription # or Link Sequence Number when reporting components for a Compound Drug)	VY: Link Sequence Number XZ : Prescription Number	REF01*XZ*123456~
2410	REF02	Reference Identification	Prescription Number or Link Sequence Number	REF01*XZ*123456~

Recommended Fields for Electronic 837 Professional (837P) and Institutional (837I) Health Care Claims

Please reference our Transaction Specific Companion Documents available on our EDI webpage. Go to empireblue.com/edi.

Recommended Fields for Paper CMS Form 1500 (02-12) Claims

If these are not completed, Claims may be delayed or returned to the Provider or Facility for additional information.

Field 1a: Insured's ID Number – from Member ID card, including any prefix

Field 2: Patient's Name – do not use nicknames or middle names

Field 3: Patient's Birth Date – date of birth should be 8-digit (MM|DD|YYYY) format and Sex

Field 4: Insured's Name – “same” is acceptable if the insured is the patient

Field 5: Patient's Address – submitted when the patient's address is different than the insured's address. If it's the same, this field does not need to be populated.

Field 6: Patient Relationship to Insured

Field 7: Insured's Address

Field 10: Is Patient's Condition Related to:

Field 10A:Employment?

Field 10B:Auto Accident?

Field 10C:Other Accident?

Field 12: Patient Authorization Signature – If patient signature is on file, “Signature on file” is acceptable

Important information about Fields 14 and 15:

CMS Form 1500 (02-12) gives Providers and Facilities two fields (14 and 15) to enter a date with a “Qualifier” that tells payers what the date is for. Field 14 is titled “Date of Current Illness, **Injury**, or Pregnancy” and field 15 is titled “Other Date”. If the visit is due to an accident, Qualifier “439” must be entered in field 15 along with the appropriate date. This information is consistent with the form instruction manual available on the NUCC website. For more guidance, please see information available on the NUCC website at www.nucc.org.

Field 14: Date of Current Illness, Injury or Pregnancy (LMP) (if applicable) – Enter the 8-digit (MM|DD|YYYY) date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported:

- 431 – Onset of current symptoms or illness
- 484 – Last Menstrual Period

Field 15: Other Date – Enter another date related to the patient’s condition or treatment. Enter the date in the 8-digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported:

- 454 – Initial treatment
- 304 – Latest visit or consultation
- 453 – Acute manifestation or a chronic condition
- 439 – Accident
- 455 – Last X-ray
- 471 – Prescription
- 090 – Report start (assumed care date)
- 091 – Report end (relinquished care date)
- 444 – First visit or consultation

Field 16: Dates Patient Unable to Work in Current Occupation – This is the time span a patient is or was unable to work

Field 17: Referring physician name – Enter the name of the referring or ordering provider. Enter the applicable qualifier to the left of the vertical, dotted line:

- DN – Referring provider
- DK – Ordering provider
- DQ – Supervising provider

Field 17b: Referring physician NPI

Field 21: Diagnosis or Nature of Illness or Injury – enter the appropriate diagnosis code/nomenclature – Relate A-L to Field 24E

Field 21: ICD Ind - ICD Indicator must be submitted between the vertical, dotted lines in the upper right-hand portion of the field or Claim may be rejected. Enter “9” for Code Set ICD-9-CM diagnosis for dates of service prior to 10/01/2015 or “0” for Code Set ICD-10 diagnosis for dates of service 10/01/2015 and later.

Field 22: Resubmission and/or Original Reference Number – ***This field is not intended for original Claim submissions.*** When resubmitting a Claim, enter the original Empire Claim number and the appropriate bill frequency code (7=Replacement of prior Claim; 8=Void/Cancel of prior Claim) left justified in the left-hand side of the field.

Field 23: ***Ambulance Providers:*** Consistent with guidance from the Centers for Medicare and Medicaid Services (CMS), please include the zip code for the point of pick up. Providers or Facilities can report the physical pick up and drop off addresses in field 32.

Claims for Laboratory Services: Include the CLIA number on each Claim billed for laboratory services by any Provider or Facility performing tests covered by CLIA.

Field 24: NDC - When submitting an NDC the NDC should be submitted in the shaded area and should be preceded with the qualifier N4, followed immediately by the 11 digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), MG (milligram) or ML (milliliter) number. The total dosage administered in mgs or mls can be reported in box 24 (the shaded section) and should not be reported in the Units field. The Units field on the CMS-Form 1500 (02-12) box 24G represents the number of units based on the NDC number.

Field 24A: Date(s) of Service

Field 24B: Place of Service

Field 24D: Procedures, Services or Supplies – Enter the appropriate CPT, HCPCS code/nomenclature; include a narrative description for Non Specific (NOC) codes. Do not use NOC codes when a specific CPT code is available. **Empire must have a clear description of the item/service billed with a NOC code to review.** Descriptions should be included in the shaded area for item 24 on professional Claim forms. Please indicate appropriate modifier when applicable.

Field 24E: Diagnosis Pointer – refer to field 21 - Be sure to enter the diagnosis code reference (pointer) from Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The references were changed from numeric to alpha characters on the updated 02/12 form version. ***Be sure to use alpha characters (A-L) and not numerics in this field.***

Field 24F: \$ Charges – line item charge.

Field 24G: Days or Units – When providing anesthesia submit time in minutes. When providing pain management, drugs, etc. it should be submitted in units.

Field 24J: Lower: National Provider Identification number (NPI)

Field 25: Federal Tax ID Number (9-digit)

Field 28: Total Charge – total of line item charges.

Field 31: Full name and title of Physician or Supplier – actual signature or typed/printed designation is acceptable.

Field 32: Service Facility Location Information – Address where services were rendered

Field 32a: Service Facility's National Provider Identification number (NPI) – Service location NPI

Field 33: Billing Provider Information and Phone # – Complete name, address, city, state and zip code
Reminder: If submitting Claims electronic, this field must hold a physical address and should not contain any of the following: "Post Office Box", "P.O. Box", "PO Box", "Lock Box", "Lock Bin", "PO Box"

Field 33a: Billing Provider's National Provider Identification number (NPI) – Billing Provider NPI

Note: To help improve payment accuracy and timeliness, please remember that when filing Claims, the Tax Identification Number (TIN) and National Provider Identifier (NPI) numbers are required. Additionally, bill Claims using the taxonomy codes as applicable.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> <input type="checkbox"/> PICA										<input type="checkbox"/> <input type="checkbox"/> PICA																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY STATE										CITY STATE																																																	
ZIP CODE TELEPHONE (Include Area Code) ()										ZIP CODE TELEPHONE (Include Area Code) ()																																																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)										b. OTHER CLAIM ID (Designated by NUCC)																																							
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE QUAL. MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										22. RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____ A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER																																																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																																											
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25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																																							
SIGNED _____ DATE _____										a. NPI b. _____										a. NPI b. _____																																							

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Recommended Fields for Paper UB-04 (CMS-1450) Claims

If these fields are not completed, Claims may be delayed or returned to the Provider or Facility for additional information.

For Inpatient and outpatient UB-04 Claim Forms – these fields must be completed:

Field 1: Provider name and complete address

Field 2: Provider's designated billing name and remittance address

Field 4: Type of Bill

Field 5: Federal Tax Identification Number

Field 6: Statement Covers Period (From-Through)

Field 8: Patient Name

Field 9: Patient Address

Field 10: Birth Date (8-digit (MM|DD|YYYY) format)

Field 11: Sex

Field 12: Admission Date

Field 13: Admission Hour

Field 14: Admission Type – Priority (Type) of Admission or Visit *[Inpatient only]*

Field 15: Admission SRC – Point of Origin for Admission or Visit *[Inpatient only]*

Field 16: Discharge Hour *[Inpatient only]*

Field 17: Patient Discharge Status *[Inpatient only]*

Fields 31-34: Occurrence Codes and Dates

Fields 39-41: Value Code(s) and Amounts

- If there is a Combined Deductible + Coinsurance + Copay amount on the EOMB greater than zero, there must be a corresponding Value code of A1, B1, C1, 08, 09, 11, A2, B2, C2 A7, B7 or C7 and amount on the UB04.
- If there is a Value Code present and not equal to 02 there must be a Value Code amount.

The Value Codes to be submitted when billing Private Room Revenue codes according to the UB-04 Data Specifications Manual 2014 and CMS Manual Transmittal 1104 are:

- **"01"** (semi-private room facility) must be accompanied by the semi-private room rate when the facility offers semi-private rooms and the patient's stay is in a private room
- **"02"** indicating "private room only" facility with \$0.00 when the facility is private room only

Common errors in Fields 39-41:

The following is a quick overview of the most common errors we are seeing on fields 39, 40 and 41, when Medicare is primary and Empire is secondary:

- Value codes are missing. Value codes A1, B1, C1 are deductibles. Value codes 09, 11, A2, B2 and C2 are coinsurance. Value codes A7, B7 and C7 are copay. Value code 06 is blood deductible.
- The member deductible is missing or does not match the EOMB (Explanation of Medicare Benefits). If there is a deductible amount indicated on the primary payer's remittance advice, the UB04 must include the member deductible (A1, B1 or C1 value code) and amount.
- The coinsurance amount is missing. If there is coinsurance on the primary payer's remittance advice, the UB04 must include the coinsurance amount (09, 11, A2, B2 or C2 value code).
- The copay amount is missing. If there is copayment on the primary payer's remittance advice, the UB04 must include the copay amount (A7, B7, or C7 value code).
- Blood deductible is not noted. If there is blood deductible on the payer's remittance advice, the value code 06 must be on the Claim, along with the amount.
- There are errors in listing multiple value codes. If more than one value code is submitted on lines a – d, please fill in fields 39a, 40a or 41a before populating 39b, 40b, or 41b.
- The value code and remittance advice amounts are different. In all cases, the value code and remittance advice amounts must match.

Field 42: Revenue Code(s) – When submitting Revenue Code 011X or 11X and/or 014X or 14X, (X = numeric value) a value code of 01 with an amount greater than zero OR a value code of 02 with zero charges or blank must also be submitted.

Field 43: Description – **NDC:** When submitting an unlisted drug HCPCS code, please submit the National Drug Code (NDC) in the shaded area above the drug code. Submit qualifier N4 followed immediately by the 11 digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), MGE (milligram) or ML (milliliter). The total dosage administered in mgs or mls can be reported in the shaded section and should not be reported in the Units field. The Service Units Field (46) represents the number of units based on the NDC number.

Field 44: HCPCS/Accommodation Rates/HIPPS Rate Codes

Field 45: Service Date

Field 46: Service Units

Field 47: Total Charges

Field 56: Providers National Provider Identification number (NPI)

Field 58: Insured's Name

Field 59: Patient's Relationship

Field 60: Insured Unique ID – from Member ID card, including any prefix/suffix

Field 66: Diagnosis and Procedure Code Qualifier (ICD Version Indicator) – The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 -Ninth Revision for dates of service prior to 10/01/2015 or 0 -Tenth Revision for dates of service 10/01/2015 and later.

Field 67: Principal Diagnosis Code and Present on Admission (POA) Indicator

Fields 67A-Q: Other Diagnosis Code(s) and Present on Admission (POA) Indicator(s)

Field 74: Principal Procedure Code and Date

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Claim Payment Disputes

Provider and Facility Claim Payment Dispute Process

If a Provider or Facility disagrees with the outcome of a Claim, the Provider or Facility may begin the Empire Claim Payment Dispute process. The simplest way to define a Claim Payment Dispute is when the Claim is finalized, but a Provider or Facility disagrees with the outcome.

Please be aware there are three common, Claim-related issues that are **not** considered Claim Payment Disputes. To avoid confusion with Claim Payment Disputes, they are defined briefly here:

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can send a Secure Message through the Availity Portal, or call the Provider Services number on the back of the Member ID Card and select the *Claims* prompt. Please reference the *Availity Portal* section for further details on Secure Messaging.
- **Claim Correspondence:** Claim Correspondence is when Empire requires more information to finalize a Claim. Typically, Empire makes the request for this information through the Explanation of Payment (“EOP”) The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Empire will use it to finalize the Claim.
- **Clinical / Medical Necessity Appeals:** An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals, please refer to the *Appeals* section within the Provider Manual.

Please reference the *Claims Submission Filing Tips* section for additional information.

The Empire Claim Payment Dispute process consists of two steps. Providers and Facilities will **not** be penalized for filing a Claim Payment Dispute, and no action is required by the Member.

1. **Claim Payment Reconsideration:** This is the first step in the Empire Claim Payment Dispute process. The Claim Payment Reconsideration represents the Provider or Facilities initial request for an investigation into the outcome of the Claim. Most issues are resolved at the Claim Payment Reconsideration step.
2. **Claim Payment Appeal:** This is the second step in the Empire Claim Payment Dispute process. If you disagree with the outcome of the Claim Payment Reconsideration, Providers or Facilities may request an additional review as a Claim Payment Appeal.

A Claim Payment Dispute may be submitted for multiple reason(s), including:

- Contractual payment issues
- Disagreements over reduced or zero-paid Claims
- Claim code editing issues
- Duplicate Claim issues

- Retro-eligibility issues
- Claim data issues
- Claims that are denied for no authorization when an authorization was obtained, a Claim Payment Dispute may be submitted as long as the authorized services match the Claim details.
- Timely filing issues*

* Empire will consider reimbursement of a Claim that has been denied due to failure to meet timely filing if the Provider or Facility can: 1) provide documentation the Claim was submitted within the timely filing requirements or 2) demonstrate good cause exists. See “Timely Filing for Claims” and “Proof of Timely Filing” in the **Claim Inquiry/Adjustment Filing Tips** section of the Manual for more information.

Claim Payment Reconsideration

The first step in the Empire Claim Payment Dispute process is called the Claim Payment Reconsideration. It is the Provider or Facilities initial request to investigate the outcome of a finalized Claim. Please note, Empire cannot process a Claim Payment Reconsideration without a finalized Claim on file.

Claim Payment Reconsiderations can be submitted via phone, the web portal, or in writing. Providers and Facilities have a minimum of 12 months from the issue date of the EOP (or such other period as set forth in their Provider or Facility Agreement.)

A determination will be made and the initial payment on the Claim will either be upheld or overturned. If the Provider or Facility is satisfied with this determination, the process will end. If the Provider or Facility disagrees with the determination of the Reconsideration, they can file a second request, called a Claim Payment Appeal.

When submitting Claim Payment Reconsiderations, Providers and Facilities should include as much information as possible to help Empire understand why the Provider or Facility believes the Claim was not paid as expected. If a Claim Payment Reconsideration requires clinical expertise, it will be reviewed by the appropriate Empire clinical professionals.

If the decision results in a Claim adjustment, the payment and EOP will be sent separately.

Claim Payment Appeal

If a Provider or Facility is dissatisfied with the outcome of a Claim Payment Reconsideration determination, Providers or Facilities may submit a Claim Payment Appeal through Availity or in writing. Please note, Providers and Facilities should submit a Claim Payment Reconsideration before a Claim Payment Appeal.

When submitting a Claim Payment Appeal, Providers and Facilities should include as much information as possible to help Empire understand why the Provider or Facility believes the Claim Payment Reconsideration determination was in error. If a Claim Payment Appeal requires clinical expertise, it will be reviewed by appropriate Empire clinical professionals.

If the decision results in a Claim adjustment, the payment and EOP will be sent separately.

Required Documentation for Claims Payment Disputes

Empire requires the following information when submitting a Claim Payment Dispute (Claim Payment

Reconsideration or Claim Payment Appeal):

- Provider or Facility name, address, phone number, email, and either NPI or TIN
- The Member's name and his or her Empire or Medicaid ID number
- A listing of disputed Claims, which should include the Empire Claim number and the date(s) of service(s)
- All supporting statements and documentation

How to Submit a Claim Payment Dispute

Mail all required documentation to:

Empire BlueCross BlueShield
Attention: Provider Correspondence
P.O. Box 1407, Church Street Station
New York, NY 10008

--Note: Correspondence received from Empire related to the Claims Payment Dispute Process may not reflect all the nomenclature outlined in this section at this time. Providers and Facilities will continue to receive the same correspondence that has been received related to these requests as they have in the past.

Medical Records Submission (Solicited and Unsolicited)

Solicited Medical Records Submission

When additional medical records are being submitted in response to Empire's request or to support an appeal, please submit them via mail or fax to the appropriate department as directed in the letter received from Empire to ensure a fast, accurate response. Always include the Empire letter requesting records **on the top of the records. A copy of the Claim is not needed.** Please **do not** place copy of Claim on top of the records.

- If Providers or Facilities are submitting X-Rays, pictures or dental molds, remember to include a valid and complete member identification number on page one of the material sent with these items.
 - Medical Records requested (solicited) by Empire needed for Claim processing can be submitted electronically using the Medical Attachments feature on the Availity Portal. The *solicited* Medical Attachments feature supports .tiff, .jpg and .pdf attachment file types. To access the *solicited* Medical Attachments tool, a provider organization's Availity administrator should complete the following steps:

From **My Account Dashboard**, select **Enrollments Center > Medical Attachments Setup**, follow the prompts and complete the following sections:

1. Select Application > Choose **Medical Attachments Registration**
2. Provider Management > Select **Organization** from the drop-down.
 - Add NPIs and/or Tax IDs.
 - Multiples can be added separated by spaces or semi-colons.
3. Assign user access by checking the box in front of the user's name. Users may be removed by unchecking their name.

- To use the *solicited* Medical Attachments tool, Availity users should complete the following steps:
 1. Log in to www.availity.com.
 2. Select **Claims and Payments > Medical Attachments > Send Attachment** tab.
 3. Complete all required fields on the form.
 4. Attach supporting documentation.

Unsolicited Medical Records Submission

Empire will send a request when medical records are required. However, if a Provider or Facility wishes to send medical records with the Claim submission, below are helpful tips to follow.

To determine what medical records or portion of the medical records may be required, refer to the applicable Empire Medical Policy, Empire Clinical Guideline, AIM Clinical Guideline, MCG at www.Empireblue.com Review the Position Statement section of the Empire Medical Policies, the Clinical Indications section of the applicable Empire or AIM Clinical Guidelines. to determine what medical records are needed. Refer to the *Medical Policies, Clinical Guidelines, and/or AIM Specialty Health* sections of the Provider Manual for details on accessing this information.

When submitting medical records that are not requested by Empire, include a clear description of the billed code submitted with the Claim to help ensure prompt processing of the Claim for all miscellaneous, not otherwise classified (NOC), not otherwise specified (NOS), and unlisted HCPCS and CPT codes.

Types of Medical Records Required

Medical records needed to determine the medical necessity of a billed code include, depending on the service or procedure, some or all of the following examples:

1. History & Physical, Office Notes, Treatment Records & Response
2. Chemotherapy Regimens, Chemotherapy Drugs, and Records
3. Medications List (current and prior)
4. Radiology, Diagnostic Imaging, or Diagnostic Testing Reports
5. Therapy/Rehabilitation Records
6. Laboratory reports, Pathology reports
7. Exact description of NOC/NOS code
8. Operative/Procedure Report
9. Inpatient Admission Summary, Daily Records, Discharge Summary

Empire May Request Additional Records

Some situations may require additional medical records in addition to what was submitted with the Claim. Although these situations may not have specific rules and guidelines, Empire will make every attempt to make these requests explicit and limited to the minimal requests necessary to render a decision. Examples include, but are not limited to, the following situations:

1. Medical records requested by a member's Blue Cross and/or Blue Shield home plan
2. Federal Employee Health Benefits Program requirements
3. Review and investigation of Claims (e.g., pre-existing conditions [for grandfathered policies of the Affordable Care Act], lifetime benefit exclusions)

4. Medical review and evaluation
5. Requests for retro authorizations
6. Medical management review (utilization review) and evaluation
7. Underwriting review and evaluation
8. Adjustments
9. Appeals
10. Quality management (quality of care concerns)
11. Records documenting prolonged services
12. Provider audits
13. Pre-pay review program
14. Fraud, waste and abuse

HIPAA Privacy Rule – Minimum Necessary

Empire complies with HIPAA Privacy Rules and will request the minimum necessary information needed to determine benefits and/or coverage associated with Claim processing. Providers and Facilities are also required under the Minimum Necessary rule to submit only those records requested.

Electronic Data Interchange (EDI) Overview

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

Empire has designated Availity to operate and serve as the electronic data interchange (EDI) Gateway. As a mandatory requirement, all trading partners who currently submit directly to the Empire EDI Gateway must transition to the Availity EDI Gateway. If Providers and Facilities wish to become a direct a trading partner with Availity, the setup is easy. Use the [Availity Welcome Application](#) to begin the process of connecting to the Availity EDI Gateway for Empire EDI transmissions. If Providers or Facilities prefer to use their clearinghouse or billing company, they must work with them to ensure connectivity through the Availity EDI Gateway.

Submitting via EDI may require additional hardware and software needed to automate other tasks in your office. No matter what method you choose to submit your transactions (direct or through a clearinghouse/billing company), Empire does not charge a fee to submit electronically. Providers and Facilities engaging in electronic transactions should familiarize themselves with the HIPAA transaction requirements.

Electronic Funds Transfer (“EFT”)

Providers or Facilities seeking to register or manage account changes for EFT will need to use the Council for Affordable Quality Health Care (CAQH) Enrollment Tool called [EnrollHub](https://solutions.caqh.org/) (at <https://solutions.caqh.org/>), a secure electronic EFT registration platform. This tool will help eliminate the need for paper registration, reduce administrative time and costs and allow Providers and Facilities to register with multiple payers at one time.

Electronic Remittance Advice (“ERA”)

Providers and Facilities must use Availity to manage all account changes and new registrations for ERA transactions.

Additional Information

For additional information concerning electronic Claims submission and other electronic transactions, Providers and Facilities can click the Electronic Data Interchange (EDI) website at <https://www.empireblue.com/provider/edi/>

Overpayments

Empire's Cost Containment Overpayment Avoidance Division reviews Claims for accuracy and requests refunds if Claims are overpaid or paid in error. Some common reasons for overpayment are:

- Paid wrong provider / Member
- Allowance overpayments
- Billed in error
- Non-covered services
- Terminated Members
- Paid wrong Member/ provider number
- Coordination of Benefits
- Late credits
- Duplicate
- Claims editing
- Total charge overpaid

Empire's Cost Containment Overpayment Avoidance Division also requests refunds for overpayments identified by other Divisions of Empire, such as Provider Audit or the Special Investigations Unit.

Empire Identified Overpayment (aka "Solicited")

When refunding Empire on a Claim overpayment that Empire has requested, please use the payment coupon included on the request letter and the following information with your check:

- **The payment coupon**
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in our refund request letter

As indicated in the Empire refund request letter and in accordance with provider contractual language, provider overpayment refunds not received and applied within the timeframe indicated will result in Claim recoupment from any Claim Provider or Facility submits to Empire.

Providers and Facilities may direct disputes of amounts indicated on an Empire refund request letter to the address indicated on the letter.

Provider and Facility Identified Overpayments (aka "voluntary" or "unsolicited")

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

- Submit a refund check with supporting documentation outlined below, or
- Submit the Refund Check Information Form with supporting documentation to have claim adjustment/recoupment done off a future remittance advice

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

- Refund Check Information Form (**see directions below for how to access online**)

- All documents supporting the overpayment including EOBs from Empire and other carriers as appropriate
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the list above of common overpayment reasons

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

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

How to access the Refund Check Information Form online:

To download the "Refund Check Information Form" directly from empireblue.com/provider/ Select Forms and search for Refund Check Information Form

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

State	Line of Business (Blue Branded)	Type of Refund	Make Check Payable To:	Regular Mailing Address:	Overnight Delivery Address:
NY	All	Voluntary	Empire Blue Cross and Blue Shield	Central Region CCOA Lockbox PO Box 73651 Cleveland, OH 44193-1177	Empire Central Lockbox 73651 4100 West 150th Street Cleveland, Ohio 44135
NY	All	Solicited Refund with Coupon Letter	Empire Blue Cross and Blue Shield	Empire Blue Cross and Blue Shield PO Box 5281 Carol Stream, IL 60197	N/A

Claims Filing Tips for New Jersey and Contiguous Border County Providers

Do you practice in a county bordering another state and have contracts with Blue Plans in your home state and the neighboring state? If so, you should file all claims with the local Blue Plan, based on where you provided the service, except when a member has coverage with the neighboring state's Blue Plan.

Here are some examples:

1. A provider is located in a New York county that borders New Jersey and has contracts with Blue

Plans in both states. When this provider renders a service to a New Jersey member, the claim is filed with Horizon Blue Cross Blue Shield of New Jersey. All other claims are filed with Empire.

2. A provider is located in a New York county that borders New Jersey. The provider has a contract with Empire, but not with Horizon. When this provider renders a service to a New Jersey Horizon member, the claim is filed with Empire.
3. You are a New Jersey provider in a border county with New York and have contracts with Horizon BCBS and Empire. Submit claims for Empire and Empire affiliate members to Empire. Submit all other claims to Horizon BCBS.
4. You are a New Jersey provider located in a border county with New York and have a contract with Empire, but not Horizon BCBS. Submit claims for Empire and Empire affiliate members to Empire. Submit all other claims to Horizon BCBS (where they will be considered non-par).

Claims filing tips for providers with multiple Blue Plans in their market

If you provide care to out-of-area Blue members from (BlueCard), follow the below claim-filing guidelines:

If you contract with both Empire and another Blue plan for the same product type (e.g. PPO or Traditional), you may file an out-of-area Blue Plan member's claim with either Plan. However, Empire and Empire affiliate members claims must be sent to Empire for processing.

Empire's Operating Area and Contiguous Counties

Empire's Service Area: 28 NY Counties	Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester	
Contiguous Counties	State	County
	6 contiguous NY counties	Broome, Chenango, Franklin, Hamilton, Herkimer, Otsego
	2 contiguous Connecticut counties	Fairfield, Litchfield
	1 contiguous Massachusetts county	Berkshire
	7 contiguous New Jersey counties	Bergen, Hudson, Middlesex, Monmouth, Passaic, Sussex, Union
	2 contiguous Pennsylvania counties	Pike, Wayne
	5 contiguous Vermont counties	Addison, Bennington, Chittenden, Grand Isle, Rutland

Indirect Care, Support and Remote Provider - An individual or organization that offers care to patients from outside the local Plan's service area. Services may be provided from a single site or from multiple locations. Examples include laboratories, Durable Medical Equipment, or Infusion Therapy Providers. Often the patient and the remote provider are in different physical locations. If you are an Indirect Care, Support and Remote providers please contact your Network Management Consultant for claim filing instructions.

General Guidelines

To facilitate claims processing, all claims must:

- Be either the uniform bill claim form or electronic claim form in the format prescribed by Empire
- Be submitted by a provider for payment by Empire for Health Services rendered to a Covered Member
- Be considered to be a Complete Claim which means, unless state law otherwise requires, must contain all information necessary to process the claim and make a benefit determination
- Be submitted within 120 calendar days of the date of service
- Include the member's name, ID number and plan prefix - exactly as it appears on the ID card include the member's relation code
- Include the member's date of birth
- Include the physician's or practitioner's name and NPI number for the plan include the physician's or practitioner's tax ID number

All providers who participate in an Empire network must have a National Provider Identification (NPI) number and are required to submit claims directly to Empire for services rendered.

All claims must be submitted in accordance with the requirements of the provider contract, and this Provider Manual. You may not seek payment for covered services from the member, except for any applicable visit fees, co-payments, deductibles, coinsurance, or penalties as described in the member's contract.

Coding Claims

Correct coding of claims expedites processing and speeds payment for services. When submitting claims or referral forms, it is important to use the most up-to date ICD-10-CM or successor codes and CPT codes.

When completing field 21 of the CMS1500 claim form, if more than one diagnosis is appropriate, list all the diagnoses that affect the treatment received. PCPs cannot bill for consultations.

To facilitate efficient claims processing the appropriate, valid procedure and diagnosis codes consistent with the member's age and gender should be submitted on claims. CPT and HCPCS modifiers assist in clarifying services and determining reimbursement. Claims reporting incompatible procedures, diagnoses and modifiers may be denied. Likewise, if an unlisted or non-descript procedure code is billed electronically, (code ending in "99") the claim will be denied. If a denial is received due to a non-descript or unlisted CPT or HCPCS code was billed, a paper claim with Medical Records attached may be submitted for consideration or the appeal process may be evoked to review the original denial.

Providers may verify benefits by calling Empire Provider Services at 1-800-992-2583, Monday – Friday, 8:30 a.m. to 5:00 p.m. EST. ID cards vary in appearance depending on the plan and employer.

Providers should keep a photocopy of the member's ID card (front and back) on file and ask the member if coverage has changed upon each visit.

Co-Payments and Cost-Sharing

Members are responsible for the co-payment amount indicated on their ID cards. Co-payments apply to

home and office visits but do not apply to in-network Annual Preventative Care visits, Well-Child Care visits, or maternity care. There may be exceptions depending on the member's contract.

Co-payments may be collected at the time of the patient's visit. Coinsurance and deductibles must be collected from members after you receive the explanation of benefits (EOB).

Per the Empire Practitioner Agreement, physician or practitioner agrees to only seek payment from a member for a health service that is not covered under the member's benefit plan, whether it is not covered because it is specifically excluded, is not considered medically necessary or is considered investigational, when the physician or practitioner has obtained a signed, [Empire Non-Covered Services Notification Wavier](#) which can be found at empireblue.com.

Claims' Review or Adjustment Requests

A provider may initiate a claims review or adjustment request for a previously processed claim due to a number of circumstances. These may include review or verification of denial of service, incorrect billing, partial payments or incorrect payments (underpayment or overpayment).

Please note that claims that have been returned to the submitter because they were inaccurate or incomplete have not been processed and consequently cannot be reviewed for adjustment. In addition, Empire cannot adjust a claim when the dollar amounts change due to the physician's corrections (such as adding a service line or a modifier). A corrected claim must be submitted and finalized for reprocessing first in these cases.

Review and Adjustment Policy

- Claim review or adjustment request must be submitted to Empire within 180 days of the original claim remittance date.
- Review of a claim does not guarantee a change in payment disposition.
- Empire will make adjustments when a claim is paid incorrectly due to an Empire error, but only if the original claim was "clean".
- If Empire mistakenly underpays a physician for a claim, Empire will make an adjustment on a subsequent remittance.
- If Empire mistakenly overpays a claim to a participating provider, Empire will request a refund from the physician on the overpaid amount or will deduct that amount from future payments.

Procedure to request review and adjustments

Claims review and adjustments may be requested in the following ways:

- Availity Secure Messaging – available at Availity.com. A guide on Availity has been included in this Manual.
- Empire's Provider Services – available Monday-Friday, 8:30 a.m. to 5:00 p.m. at 1-800-552-6630. Representatives may be able to take information over the phone to initiate a review or adjustment on your behalf. A guide to our IVR has been included in the Exhibit section of this Manual.
- Provider correspondence – Providers may mail request for review and adjustment with additional documentation to:
Empire BlueCross BlueShield
Attention: Provider Correspondence
P.O. Box 1407, Church Street Station

Required information when requesting review and adjustments

In order to adequately address concerns regarding claims processing, Empire must require the following data to initiate a review and adjustment on your behalf. Failure to provide any of the necessary information will impact our ability to identify and review the claim in question.

- Member's plan issued identification number with prefix
- Dependent number
- Date of service
- Claim number
- Reason for the request to review and adjust the claim

Medicare Crossover**Duplicate Claims Handling for Medicare Crossover**

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

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

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

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

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

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

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

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

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

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

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

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

Effective October 13, 2013:

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

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

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

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

The GY modifier *should not* be used when submitting:

- Federal Employee Program Claims
- Inpatient institutional Claims. Please use the appropriate condition code to denote statutorily excluded services.

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

Medicare Crossover Claims FAQs

1. How do I handle traditional Medicare-related Claims?

- When Medicare is primary payer, submit Claims to your local Medicare intermediary.
- All Blue Claims are set up to automatically cross over (or forward) to the Member’s Blue Plan after being adjudicated by the Medicare intermediary.

2. How do I submit Medicare primary / Blue Plan secondary Claims?

- For Members with Medicare primary coverage and Blue Plan secondary coverage, submit Claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the Claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the Member’s ID card for additional verification.
- Be certain to include the three-character prefix as part of the Member identification number. The Member’s ID will include the three-character prefix in the first three positions. The three-character prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the Claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance advice indicates that the Claim was crossed over, Medicare has forwarded the Claim on your behalf to the appropriate Blue Plan and the Claim is in process. **DO NOT** resubmit that Claim to Empire; duplicate Claims will result in processing and payment delays.
- If the remittance advice indicates that the Claim was not crossed over, submit the Claim to your local Empire Plan with the Medicare remittance advice.
- In some cases, the Member identification card may contain a COBA ID number. If so, be certain to include that number on your Claim.
- For Claim status inquiries, please contact your local Empire Plan.

3. Who do I contact with Claims questions?

- Your local Empire Plan.

4. How do I handle calls from Members and others with Claims questions?

- If Members contact you, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number.
- A Member's Blue Plan should not contact you directly, unless you filed a paper Claim directly with that Blue Plan. If the Member's Blue Plan contacts you to send another copy of the Member's Claim, refer the Blue Plan to your local Empire Plan.

5. Where can I find more information?

For more information:

- Visit Empire's Web site at www.empireblue.com.
- Please contact your local Empire Plan.

Reimbursement Requirements and Policies

This section includes reimbursement guidelines and policies on how Empire will reimburse Providers and Facilities for certain services. Reimbursement Policies are published on empireblue.com be sure to check both places. To locate the policies online go to www.Empireblue.com. Empire reserves the right to review and revise policies when necessary.

Blood, Blood Products, and Administration

Transportation charges are included in the reimbursement for the product itself and are not separately reimbursable. Blood and blood product administration services are not reimbursable on inpatient Claims.

Changes during Admission

There are elements that could change during an admission. The following table shows the scenarios and the date to be used for the entire Claim:

CHANGE	EFFECTIVE DATE
Facility's Contracted Rate (other than DRG)	Admission
DRG Base Rate	Discharge
DRG Grouper	Discharge
DRG Relative Weight	Discharge
CPT & HCPCS coding changes	Discharge

Coding Requirements

Providers and Facilities will submit Claims in a format consistent with industry standards and acceptable to Empire.

Comprehensive Health Planning

Facility shall not bill Empire, Plan or a Member for Health Services, expanded facilities, capital operating costs or any other matter of service requiring a certificate of need approval or exemption under existing law, or similar or successor laws that may be adopted from time to time, unless said approval or exemption has been granted in writing.

Courtesy Room

Facility shall not bill Empire, Plan, and/or Members for any charges related to use of a Courtesy Room in the provision of Health Services to a Member. "Courtesy Room" means an area in the Facility where a professional provider is permitted by Facility to provide Health Services to Members.

Daily Supply or One Time Charge Fees/Items

Supply fees billed daily or one time, which are unidentified and unsupported by medical records or documentation are not reimbursable.

Eligibility and Payment

A verification of eligibility is not a guarantee of payment.

Emergency Room Supply and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supply, time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients.

Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech, call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

General Industry Standard Language

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

Implants

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

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

Instrument Trays

Charges for instrument trays for any procedure are included in the cost of the procedure and are not separately reimbursable. See Operating Room Time and Procedure Charges for additional information.

IV Sedation and local anesthesia

Charges for IV Sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room ("OR") time/procedure reimbursement.

Lab Charges

Venipuncture, specimen collection, draw fees, phlebotomy, heel stick, processing fees, handling fees, blood storage and processing, blood administration, thawing fees. These charges are inclusive of the primary procedure/lab test performed and not separately reimbursable.

Labor Care Charges

Empire will reimburse appropriately billed room and board or labor charges. Payment will not be made on both charges billed concurrently. Facilities reimbursed under DRG will not be reimbursed by Empire for Outpatient Services rendered prior to the admission.

Medical Care Provided to or by Family Members

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

Unless otherwise set forth in a Member's Health Benefit Plan, an immediate family Member includes: father, mother, children, spouse, domestic partner, legal guardian, grandparent, grandchild, sibling, step-father, step-mother, step-children, step-grandparent, step-grandchild, and/or step-sibling.

Non-Participating Provider Claims Payment

Empire has established Maximum Allowed Amounts for services rendered by non-participating providers. Once Empire determines the appropriate Maximum Allowed Amount for services provided by a non-participating provider, the payment will be remitted to the Member in most situations rather than the non-participating provider.

Nursing Procedures

Empire will not separately reimburse fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing

(such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Observation Services (Facility Reimbursement Policy)

Empire considers outpatient observation services to mean active, short-term medical and/or nursing services performed by an acute Facility on that Facility's premises that includes the use of a bed and monitoring by that acute Facility's nursing or other staff and are required to observe a patient's condition to determine if the patient requires an inpatient admission to the Facility. Observation services include services provided to a patient designated as "observation status. Observation services may be considered eligible for reimbursement when rendered to patients who meet one or more of the following criteria:

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

Policy

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

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

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

- Physician, patient, and/or family convenience
- Routine preparation and recovery for diagnostic or surgical procedures
- Social issues
- Blood administration
- Cases routinely cared for in the Emergency Room or Outpatient Department

- Routine recovery and post-operative care after outpatient surgery
- Standing orders following outpatient surgery
- Observation following an uncomplicated treatment or procedure

Operating Room Time and Procedure Charges

The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel
- Linen packs, basic instrument packs, basic packs, basic post-op dressing, equipment and routine supplies such as sutures, gloves, dressings, sponges, prep kits, drapes, and surgical attire.

Separate charges are allowed for specialized packs such as those used for open heart, eye and scope surgeries, packs for extensive plastic repair and complex post-op dressing or specialized equipment such as hip pins, bone nails, bone plates, and tantalum mesh. This includes the cost of preparing, storing and handling such supplies.

The operating room charge will not reflect the cost of robotic technology and is not eligible for separate reimbursement. Examples of charges that are not eligible for separate or additional reimbursement are listed below:

- Increased operating room unit cost charges for the use of the robotic technology
- Charges billed under CPT or HCPCS codes that are specific to robotic assisted surgery, including, but not limited to, S2900

Other Agreements

If Facility currently maintains a separate Agreement(s) with Empire solely for the provision and payment of home health care services, skilled nursing Facility services, ambulatory surgical Facility services, or other agreements that Empire designates (hereinafter collectively "Other Agreement(s)"), said Other Agreement(s) will remain in effect and control the provision and payment of Covered Services rendered there under.

Personal Care Items

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

Pharmacy Charges

Pharmacy charges will include the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. Empire will reimburse at the Empire Rate for the drug. All other services are included in the Empire Rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees and Facility staff checking the pharmacy ("RX") cart.

Place of Service and Evaluation & Management (Facility Reimbursement Policy)

This provision describes Empire's policy regarding Facility reimbursement for services provided outside of the primary structure on the campus of a hospital or institutional provider and for Evaluation & Management (E&M) services provided within the primary structure on the campus of a hospital or institutional provider.

The primary structure on the campus of a hospital or an institutional provider is the physical site location where there are state licensed inpatient beds and/or a state licensed emergency room or emergency department, as well as provision of 24 hours per day seven days a week on site continuous physician and nursing services for diagnosis and treatment of patients.

E&M services are defined as professional services rendered by a physician or other qualified health care professional for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. E&M services typically include development of medical history, physical examination, medical decision making or counseling and coordination of care.

Policy

- Services that are rendered in an office, professional building, medical office building, clinic or a space owned by a hospital or an institutional provider, other than the primary structure on the campus of the hospital or institutional provider, or rented by a professional from the hospital or an institutional provider, must be billed on a CMS-1500 Claim form and are not reimbursable if they are billed on a UB-04 claim form.
- Empire shall not separately reimburse a clinic fee or any other Facility fee associated with space used to provide E&M services in the event they are billed on a UB-04 claim form
- Empire does not reimburse for professional E&M charges billed on a UB-04 claim form regardless of where services are rendered; reimbursement for these charges are included in the professional fee allowance.
- All professional services including, but not limited to, those rendered by hospital-based physicians such as emergency room physicians, radiologists, anesthesiologists, hospitalists, independent practitioners, physical therapists, occupational therapists, speech therapists, and Certified Registered Nurse Anesthetists (CRNA) must be billed on a CMS-1500 claim form using the appropriate CPT®/HCPCS codes.
- Services rendered outside of the primary structure on the campus of a hospital or an institutional provider shall not be billed or reimbursed on a UB-04 claim form. The Member is not responsible for these charges.

Examples of Revenue Codes under which such services shall not be billed or reimbursed include, but are not limited to, the following groupings:

0280 – 0289 Oncology Clinic
0300 – 0309 Laboratory
0300 – 0319 Laboratory Pathological
0320 – 0329 Radiology Diagnostic
0330 – 0339 Radiology – Therapeutic and/or Chemotherapy Administration
0340 – 0349 Nuclear Medicine
0350 – 0359 CT Scan
0420 – 0429 Physical Therapy
0430 – 0439 Occupational Therapy
0440 – 0449 Speech Therapy
0481 – 0489 Cardiology Clinic
0510 – 0519 Clinic
0520 – 0529 Free Standing Clinic
0530 – 0539 Osteopathic Services
0540 – 0549 Ambulance
0610 – 0619 Magnetic Resonance Technology
0630 – 0637 Pharmacy
0740 – 0749 Sleep Study
0760 – 0769 Treatment or Observation Room
0770 – 0779 Preventive Care Codes
0780 – 0789 Telemedicine
0960 – 0989 Professional Fees

Professional E&M services shall not be reimbursed on a UB-04 Claim form. The Member is not responsible for these charges.

Portable Charges

Portable Charges are included in the reimbursement for the procedure, test or x-ray and are not separately reimbursable.

Pre-Operative Care or Holding Room Charges

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure, and are not separately reimbursed. In addition, nursing care provided in the pre-operative care area will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

Preparation (Set-Up) Charges

Charges for set-up, equipment or materials in preparation for procedures or tests are included in the reimbursement for that particular procedure or test.

Preventable Adverse Events (Facility Reimbursement Policy)

Acute Care General Hospitals (Inpatient)

Three (3) Major Surgical Never Events

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

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

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

CMS Hospital Acquired Conditions (“HAC”)

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

When a HAC does occur, all inpatient acute care Facilities shall identify the charges and/or days which

are the direct result of the HAC. Such charges and/or days shall be removed from the Claim prior to submitting to the Plan for payment. In no event shall the charges or days associated with the HAC be billed to either the Plan or the Member.

Providers and Facilities (excluding Inpatient Acute Care General Hospitals)

Four (4) Major Surgical Never Events

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

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

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

Provider and Facility Records

Provider and Facility shall prepare and maintain all appropriate medical, financial, administrative and other records as may be needed for Members receiving Health Services. All of Provider’s and Facility’s records on Members shall be maintained in accordance with prudent record keeping procedures and as required by any applicable federal, state or local laws, rules or regulations.

Recovery Room Charges

Reimbursement for recovery room services (time or flat fee) includes all used and or available services, equipment, monitoring, nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include, but is not limited to EKG monitoring, Dinamap®, pulse oximeter, injection fees, nursing, nursing time, nursing supervision, equipment and supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Respiratory Services Not Eligible for Separate Reimbursement

More than one type of respiratory support (for example: mechanical ventilation and CPAP) at the same time **and/or on the same day is not eligible for separate reimbursement**, unless there is clinical documentation to support that the Member requires different levels of respiratory support.

Routine Supplies

Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

All items and supplies that may be purchased over-the-counter are not separately reimbursable.

All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately reimbursable.

All reusable items, supplies and equipment that are provided to all patients admitted to a given treatment area or unit (i.e., NICU, Burn Unit, PACU, Medical/Surgical Unit), as well as all reusable items, supplies and equipment that are provided to all patients receiving the same service (i.e., an Ambu bag during resuscitation), are not separately reimbursable.

Special Procedure Room Charge

Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by Charges

Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. Professional staff on standby is included in the reimbursement for the procedure and also is not separately reimbursable.

Stat Charges

Stat charges are included in the reimbursement for the procedure, test and or X-ray. These charges are not separately reimbursable.

Submission of Claim/Encounter Data

Facilities and Providers will submit Claims and encounter data to Empire on a CMS-1500, UB04, or

subsequent form, in a manner consistent with industry standards and policies and procedures as approved by Empire. Empire will make best efforts to pay all complete and accurate Claims for Covered Services submitted by Facilities and Providers in accordance with the applicable state statute, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, to the extent of our payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage.

Supplies and Equipment

Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, and isolation carts and supplies are not separately reimbursable. Also, oxygen charges, including but not limited to, oxygen per minute, per hour and therapy, when billed with room types ICU/CCU/NICU or any Specialty Care area, where equipment is a requirement to be authorized for specialty category, are not separately reimbursable.

Tech Support Charges

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, are not separately reimbursable.

Telemetry

Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable. Separately billed telemetry charges will only be paid if observation ("OBS") charges do not exceed approved average semi-private room and board rate less discount, as submitted to Empire.

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

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

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

Non-diagnostic services are also considered part of pre-admission/pre-surgical/preoperative testing if

they are furnished in connection with the principal diagnosis that necessitates the outpatient procedure or the Member's admission as an inpatient.

Unless the Provider or Facility Agreement with Empire specifies a different timeframe, pre-admission/pre-surgical/ pre-operative testing that occurs within seventy-two (72) hours prior to the inpatient admission or outpatient procedure will be included in the DRG Rate, Per Diem Rate, Case Rate or any other Anthem Rate for Covered Services, and will not be paid separately. All Claims billed separately for these services must be accompanied with the appropriate ICD-10 codes.

Undocumented or Unsupported Charges

Per Empire policy, Empire will not reimburse charges that are not documented on medical records or supported with reasonable documentation.

Video or Digital Equipment used in Operating Room

Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges

For any claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. The disallowed charges (charges not eligible for reimbursement) include, **but are not limited to**, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services:

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0990 – 0999	Personal Care Items <ul style="list-style-type: none">• Courtesy/Hospitality Room• Patient Convenience Items (0990)• Cafeteria, Guest Tray (0991)• Private Linen Service (0992)• Telephone, Telegraph (0993)• TV, Radio (0994)• Non-patient Room Rentals (0995)• Beauty Shop, Barber (0998)• Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment <ul style="list-style-type: none"> • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes, etc. • Pacing Cables/Wires/Probes • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose; • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires • Oral swabs/toothettes; • Wipes (baby, cleansing, etc.) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits; • Tourniquets; • Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies; • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges; • Kerlix/Tegaderm/OpSite/Telfa • Skin cleansers/preps; • Cotton Balls; Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solutions

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> • ID/Allergy bracelets; • Foley stat lock; • Gloves/Gowns/Drapes/Covers/Blankets; • Ice Packs/Heating Pads/Water Bottles • Kits/Packs (Gowns, Towels and Drapes); • Basins/basin sets; • Positioning Aides/Wedges/Pillows; • Suction Canisters/Tubing/Tips/Catheters/Liners • Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) • Preps/prep trays; • Masks (including CPAP and Nasal Cannulas/Prongs); • Bonnets/Hats/Hoods; • Smoke Evacuator Tubing; • Restraints/Posey Belts • OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) • IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, etc.);
0220 – 0222, 0229, 0250	Tech Support Charges <ul style="list-style-type: none"> • Pharmacy Administrative Fee (including mixing meds) • Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) • Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366); IV Infusion additional for therapy: IV Infusion concurrent for therapy (96368); IV Injection (96374, 96379)
0229, 0760 – 0762, 0769, 0270, 410 – 413, 0419	Other Special Charges <ul style="list-style-type: none"> • Oxygen charges while a patient is on a ventilator

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> Respiratory assessment/vent management charges
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) <ul style="list-style-type: none"> Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less Miscellaneous Descriptions Non-FDA Approved Medications
0256	Experimental Drugs
0270, 0300 – 0307, 0309,	Venipuncture (CPT Code 36415, 36416 or G0001) <ul style="list-style-type: none"> Specimen collection Draw fees Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399)

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> Thawing/Pooling Fees
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment <ul style="list-style-type: none"> Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and, as such, included in the room and board Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery Instrument Trays and/or Surgical Packs Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heal/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies When Billed with Anesthesia Time Charges Anesthesia Circuit Perfusion Supplies When Billed with Perfusionist Time Charge Case Carts C-Arm/Fluoroscopic Charge

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<ul style="list-style-type: none"> • Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Davinic Machine/Robot
0309 – 0369, 0419, 0619	After Hours – Call-back
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (Specifically, conscious/moderate sedation) <ul style="list-style-type: none"> • Nursing care • Monitoring • Intervention • Pre- or Post-evaluation and education • IV sedation and local anesthesia • Intubation/Extubation • CPR
410	Nursing/Respiratory Functions: <ul style="list-style-type: none"> • Oximetry (94760, 94761, 94762) • Oximetry reading by nurse or respiratory tech • Vent Management • Postural Drainage • Suctioning Procedure • Nursing/Respiratory care performed while patient is on vent
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)

Member Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0110 – 0119	Private Room*
0990	Patient Convenience Items
0991	Cafeteria, Guest Tray
0992	Private Linen Service
0993	Telephone, Telegraph
0994	TV, Radio
0995	Non-patient Room Rentals
0996	Late Discharge
0998	Beauty Shop, Barber
0999	Other Patient Convenience Items

* Subject to the Member's Benefit Agreement.

Facility Payment Methodologies

General Rules Relating to Facility Payment Methodologies

Services are reimbursed using a Case Rate, Per Diem, Per Visit, Fee Schedule Rate, Percentage Rate and Other Outpatient Rate payment methodology based on the Facility Agreement. These allowances include, but is not limited to, reimbursement for professional services, blood, blood products, processing, storage and administration, monitoring services performed in connection with devices inserted or equipment used in part of an Inpatient or Outpatient Service, comprehensive health planning, courtesy room, daily supply or one time charge fees/items, Facility personnel charges, instrument trays, implants, equipment and supplies, drugs/medications, nursing procedures, all ancillary services (including but not limited to laboratory and x-ray), DME, room and board charges, personal care items, portable charges, pre-operative care and holding room charges, preparation charges, ambulance charges, recovery room, special procedure room charge, stand-by charges and video equipment used in operating room.

Rounding of Allowances

Covered Services priced at a Case Rate, Per Diem Rate or Per Visit rate, including those being modified for the Q-HIP adjustment, if applicable, will be rounded to the nearest whole dollar. In addition, the base rate used to calculate the DRG Case Rate shall be rounded to the whole penny to the extent applicable.

Covered Services priced at a Fee Schedule Rate, including those being modified for the Q-HIP adjustment, will be calculated using whole percentages. The resulting Fee Schedule Rate allowance will be rounded to two (2) decimal places.

Covered Services priced at a Percentage Rate will be rounded to two (2) decimal places. By way of example but not limited to, if the Empire Rate requires a price adjustment due to an audit finding, the resulting Percentage Rate will be modified and rounded to two (2) decimal places.

If applicable, when Q-HIP adjustment and inflationary Rate Increases coincide on the same effective date, the Q-HIP adjustment and the rate increase will first be added together and the result will be applied to the Empire Rate using the rounding rules previously detailed above. For illustrative purposes only, if the rate increase was 3.5%, the Q-HIP adjustment was 0.85%, the Empire Rate was \$755 Per Diem, and the inflationary Empire Rate with Q-HIP adjustment would equal \$.

$(1.035 + .0085) \times 755 = 1.0435 \times 755 = \787.8425 which would be rounded to \$788.

Billing Policy & Procedure Overview

Inpatient Services and Ambulatory Surgery Claims

The guidelines below must be followed when submitting inpatient and ambulatory services claims:

- Well-Baby newborn claims do not require authorization if there is an authorization on file for the mother
- Preadmission testing does not require a separate authorization when the related inpatient or ambulatory surgery precertification has been confirmed
- Preadmission or presurgical testing claims may not be submitted until the surgery or inpatient claim has been submitted to us
- Preadmission or presurgical testing claims are never payable separately when performed in advance of a covered admission or ambulatory surgery.

Outpatient CPT Based Claims

For those providers who have contracted for outpatient CPT processing, we will process (based on individual contract with facility) outpatient diagnostic, therapy, home infusion and ambulatory surgery claims based on CPT codes that are billed in conjunction with revenue codes based on the Medicare Physician Fee Schedule Non-Facility allowable as indicated at www.cms.gov. If there is no allowable indicated at www.cms.gov, the services will be reimbursed at Empire's standard reimbursement fee schedule which may be updated from time to time.

CPT outpatient ambulatory surgery claims will be reimbursed based on the revenue code and CPT surgical procedure code. We will reimburse multiple CPT surgical procedure codes. Empire does not accept Modifier 50 for claims processing, so bilateral procedures reported with the same CPT/HCPCS must be billed on separate lines using an LT/RT Modifier.

Medicare crossover claims are excluded from the CPT payment methodology, as we reimburse Medicare balances only.

Late Charges

If you are billing for late charges to an already adjudicated claim, you must use X12 837 version 4010A

electronic transaction format. For inpatient claims, the original room charges must be reported with Type of Bill 115. For outpatient claims, just the late charges must be reported with Type of Bill 135.

Corrected Bills

If you are billing a corrected claim you must use the X12 837 version 4010A electronic transaction format when submitting the request for a corrected bill. For inpatient claims, submit with Type of Bill 117. For outpatient claims, submit with Type of Bill 137.

General Coding and DRG Validation Review

Empire has contracted with independent, experienced healthcare evaluation and quality improvement organizations to perform a diagnostic related group (DRG) validation review on negotiated case rates. Audits on payments are a part of your Participation Agreement with Empire.

The reviewers will select cases for review. They will review the medical records with facility staff to validate each coding and DRG assignment. All information obtained from the review will be kept confidential and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations.

Our contracted reviewers may request to review records at your site or off-site. We ask that you accommodate both requests. The vendors will perform their evaluations with minimal disruption to the Facility staff while performing an on-site review.

The vendors will notify you of the outcome of the review. If a reviewer identifies an overpayment to your facility for any reviewed DRG, Empire will make appropriate adjustments to the payments. If the reviewer is unable to review the records, Empire will make adjustments to payments based upon the information available to us at that time. Any adverse determination will be subject to the appeal rights specified in your contract.

As of this printing, Empire's contracted reviewer(s) include:

- Meridian Resource Company
- Equicclaim

Chargemaster Cap

Facility will provide thirty (30) days prior written notice of any increase to the Chargemaster above the Chargemaster Cap set forth in the Agreement, via certified letter from the Facility's chief financial officer or other appropriate officer of Facility. Such notice shall include Facility's estimate of the amount of net increase based on the book of business covered under the Agreement and shall provide a copy of the Chargemaster.

Empire shall have the right, upon request and consistent with the audit provisions of the Agreement, to audit any and all Facility records, documents and other information to validate the net impact of the Chargemaster increase. The audit will be conducted using inpatient and outpatient utilization for all Claims paid under this Agreement and will be conducted using the revenue and usage (utilization) data for the fiscal period (annual) subject to audit as opposed to using fiscal period data from any other period than the audit.

In the event the Facility increases its Chargemaster, in the aggregate, taking into account the book of

business under this Agreement, by more than the Chargemaster Cap during any applicable contract year, the parties agree that the Percentage Rate paid will be decreased by a percentage equal to the percent in excess of the Chargemaster Cap by Empire. In other words, Empire shall decrease the discount off charges for any Covered Services paid on a Percentage Rate basis to ensure that the amount payable under this Agreement does not exceed the amount that would have been payable had the Facility not exceeded the Chargemaster Cap. Plan reserves the right to recoup any amounts paid over the Chargemaster Cap between the time that the Chargemaster increase caused payments to exceed the Chargemaster Cap until the payment rates were adjusted downwardly to bring Facility into compliance with this section.

Facility will make Chargemaster available to Empire electronically upon request. This data shall be in a format acceptable to Empire and shall include, at a minimum, the following data elements: (1) all Facility charge codes and related charge revenue (Coded Service Identifier(s)); (2) charge number; (3) current Charge and previous Charge; (4) effective date of change; (5) departmental code; and (6) Facility tax identification number.

Medical Policies

Medical Policies and Clinical Utilization Management (“UM”) Guidelines

The Office of Medical Policy & Technology Assessment (“OMPTA”) develops medical policy and clinical UM guidelines (collectively, “Medical Policy”) for Empire. The principal component of the process is the review for development of Medical Necessity and/or investigational policy position statements or clinical indications that are objective and based on clinical evidence for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services consisting of medical, surgical, and behavioral health treatments may include, but are not limited to devices, biologics, specialty pharmaceuticals, gene therapies, and professional health services.

The Medical Policy & Technology Assessment Committee (“MPTAC”) is a multiple disciplinary group including physicians from various medical and behavioral health specialties, clinical practice environments and geographic areas. Voting membership may include external physicians in clinical practices and participating in networks, external physicians in academic practices and participating in networks, internal medical directors and Chairs of MPTAC Subcommittees. Non-voting members may include internal legal counsel and internal medical directors.

Additional details regarding the Medical Policy development process, including information about MPTAC and its Subcommittees, is provided in [ADMIN.00001 Medical Policy Formation](#) -

Medical Policy and Clinical Utilization Management (“UM”) Guidelines Distinction

Medical Policy and clinical UM guidelines differ in the type of determination being made. Both set forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures. In general, Medical Policy may be developed to address experimental or investigational technologies (including a novel application of an existing technology) and services where there is a significant concern regarding Member safety. Clinical UM guidelines address Medical Necessity criteria for technologies or services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay (GLOS), place of service and level of care. In addition,

Medical Policies are implemented by all Empire Plans while clinical UM guidelines are adopted and implemented at the local Empire Plan or line of business discretion.

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

All Empire Medical Policy is publicly available on our website, which provides transparency for Providers and Facilities, Members and the public in general. Some vendor guidelines used to make coverage determinations are proprietary and are not publicly available on the Empire website, but are available upon request.

To locate Medical Policy online, go to empireblue.com. Select **Providers**, then scroll to or select Policies, Guidelines and Manuals from the horizontal menu under Provider Resources. Scroll to Medical Policies & Clinical UM Guidelines and select “View Medical Policies & Clinical UM Guidelines”. Search for policies or select “Full List page” to view. Page link is included below:

- [Medical Policy and Clinical UM Guidelines](#)

To locate Medical Policy and Clinical UM Guidelines and Prior Authorization requirements for BlueCard Out-of-area members go to www.Empireblue.com. Select Providers, then choose “Prior Authorization” under Claims in the horizontal menu. Scroll down the page to Helpful Links and select “Medical Policy and Prior Authorization for Blue Plans”. Page link is included below:

- [Medical Policy and Prior Authorization for Blue Plans](#)

Clinical UM Guidelines

The clinical UM guidelines published on our website represent the clinical UM guidelines currently available to all Plans for adoption throughout our organization. Because local practice patterns, claims systems and benefit designs vary, a local Plan or line of business may choose whether to implement a particular clinical UM guideline. The link below can be used to confirm whether the local Plan or line of business has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan or line of business.

To view the list of specific clinical UM guidelines adopted by New York, scroll to the bottom of the Clinical UM Guidelines section and select the link titled “[Clinical UM Guidelines adopted by Empire BlueCross BlueShield.](#)”

Manual Section Name: Investigational Procedures

Medical policy *ADMIN.00005 Investigational Criteria* provides the following criteria:

"Investigational" means that the procedure, treatment, supply, device, equipment, facility or drug (all services) does not meet Empire’s Technology Evaluation Criteria because it does not meet **one or more** of the following criteria:

- have final approval from the appropriate government regulatory body; **or**
- have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; **or**

- be proven materially to improve the net health outcome; **or**
- be as beneficial as any established alternative; **or**
- show improvement outside the investigational settings.

In addition to the above criteria, the Medical Policy & Technology Assessment Committee (“MPTAC”) will consider recommendations of national physician specialty societies, nationally recognized professional healthcare organizations and public health agencies, and in its sole discretion, may consider other relevant factors, including information from the practicing community.

Utilization Management

Utilization Management Program

The Utilization Management (“UM”) Program goal is to have Members receive the appropriate quantity and quality of healthcare services, delivered at the appropriate time, and in a setting consistent with their medical care needs. Providers and Facilities agree to abide by the following UM Program requirements in accordance with the terms of the Agreement and the Member’s Health Benefit Plan. Providers and Facilities agree to cooperate with Empire in the development and implementation of action plans arising under these programs. Provider or Facility shall comply with all requests for medical information required to complete Empire’s UM review. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined within this section.

UM Definitions

1. **Adverse Determination:** means a denial, reduction or failure to make payment (in whole or in part) for a benefit based on a determination that a benefit is experimental, investigational, or not medically necessary or appropriate as defined in the applicable health benefit plan. This may apply to Prospective, Continued Stay, and Retrospective reviews.
2. **Business Day:** Monday through Friday, excluding designated company holidays.
3. **Continued Stay Review:** (continuation of services). Continued Stay Review means utilization review that is conducted during a Member’s ongoing stay in a facility or course of treatment. Continued Stay Review includes continuation of services (Urgent Care & Extensions).
4. **Notification:** The telephonic and/or written/electronic communication to the applicable Providers, Facility and the Member documenting the determination, and informing the Member, Providers, and Facility of their rights if they disagree with the determination.
5. **Pre-certification/Pre-authorization Requirement:** List of procedures that require Pre-service Review by Empire UM prior to service delivery. For Empire UM team to perform Pre-service Review, the provider submits the pertinent information as soon as possible to Empire UM prior to service delivery.
6. **Pre-Service (Prospective) Review:** Review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Member.
7. **Post Service (Retrospective) review:** means a utilization review that is conducted after the health care service (or supply) has been provided to the Member.

8. **Urgent Care Review:** means request for medical care or services where application of the time frame for making routine or non-life threatening care determinations.
- Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment, or
 - Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or
 - In the opinion of a practitioner who is a licensed or certified professional providing medical care or behavioral healthcare services with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

Program Overview

Utilization Management (UM) may be required for Pre-certification/Pre-authorization, Pre-service (Prospective) Review, Continued Stay Review, or Post-service (Retrospective) Review.

The determination that services are medically necessary is based on the information provided, and is not a guarantee that benefits will be paid. Payments are based on the Member's coverage at the time of service. These terms typically include certain exclusions, limitations and other conditions. Benefit payment could be limited, for example, when:

- The information submitted with the Claim, or on the medical record, differs from that given by telephone, fax or electronic communication.
- The service is excluded from coverage.
- The Member is not eligible for coverage when the service is provided.

The review may consider such factors as the Medical Necessity of services provided, and whether the service involves cosmetic or experimental/investigative procedures.

UM may be conducted via multiple communication paths.

Inpatient medical admissions require UM review. UM for inpatient medical services may include but is not limited to: acute hospitalizations, units described as "sub-acute," "step-down" and "skilled nursing facility;" designated skilled nursing beds/units; comprehensive outpatient rehabilitation Facilities; rehabilitation units; inpatient hospice; and sub-acute rehabilitation Facilities or transitional living centers. These services are subject to admission review for determination of Medical Necessity and appropriateness, site of service and level of care.

Non-inpatient medical services may require Pre-Service Review.

The list of **Pre-certification/Pre-authorization Requirements** can be accessed online at www.Empireblue.com.

Pre-service Review & Continued Stay Review

- Provider or Facility shall ensure both requirements (1) and (2) are met: (1) that non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Empire are submitted for review and have a decision rendered before the service occurs. Information provided to Empire UM shall include demographic and clinical information

including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance see Failure to Comply with Utilization Management Program section. (2) For non-emergency admissions, Provider or Facility shall also provide confirmation to Empire UM of the necessary demographic information and primary diagnosis within twenty-four (24) hours or next Business Day following the Member's admission.

- B. If an Emergency admission has occurred, Provider or Facility shall notify Empire UM within forty-eight (48) hours or the first Business Day following admission. If the forty-eight (48) hours expires on a day that is not a Business Day the timeframe will be extended to include the next Business Day. Information provided to Empire UM shall include demographic and clinical information including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance see Failure to Comply with Utilization Management Program section.
- C. Provider or Facility shall verify that the Member's primary care physician has provided a referral as required by certain Health Benefit Plans.
- D. Provider or Facility shall comply with all requests for medical information required to complete Empire's UM review up to and including discharge planning coordination. To facilitate the review process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.
- E. Empire specific Pre-certification/Pre-authorization Requirements may be confirmed on the Empire web site or by contacting the appropriate phone number on the back of the Member's ID card.
- F. When the review is completed, Empire will provide electronic or written Notification for all Adverse Determinations to the Member and attending practitioner or treating practitioner, as applicable. .
- G. UM Review Timeframes follow State, Federal and accreditation requirements as may be applicable to the review.

Medical Policies and Clinical UM Guidelines

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

On-Site Review

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

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

Certain services such as Transplant may be excluded from on-site review.

Discharge Planning

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

Observation Bed Policy

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

Retrospective Utilization Management

Medical records and pertinent information regarding the Member's care may be reviewed to make a Claim determination.

Failure to Comply With Utilization Management Program

Provider and Facility acknowledge that Empire may apply monetary penalties such as a reduction in payment, as a result of Provider's or Facility's failure to provide notice of admission or obtain Pre-service Review on specified outpatient procedures, as required under this Agreement or for Provider's or Facility's failure to fully comply with and participate in any cost management programs and/or UM programs. Members may not be balance billed for penalty amounts.

Utilization Statistics Information

On occasion, Empire may request utilization statistics for disease management purposes using Coded Services Identifiers. These may include, but are not limited to:

- Member name
- Member identification number
- Date of service or date specimen collected
- Physician name and/or identification number
- HEDIS Measures or any other pertinent information Empire deems necessary

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

Electronic Data Exchange

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

Interactive Care Reviewer (ICR)

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

- Initiate pre-authorization requests online, eliminates the need to fax.
- Allows detailed text, photo images and attachments to be submitted along with your request.
- Make inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Instant accessibility from almost anywhere including after business hours.
- Update clinical information when the case is still active.
- Update the case with extension of services or discharge information.
- View, download or print all Provider letters associated to the case.
- Utilize the dashboard to provide a complete view of all ICR submitted UM and behavioral health requests with real time status updates.
- Email *Notifications* if requested using a valid email address to notify activity on the case.
- Real time decisions for some common procedures.
- Access ICR under Authorizations and Referrals via the Availity Portal.
- Request clinical Appeals for any eligible **denied** authorization affiliated with your tax id / organization.
- Check the status of clinical appeals.

To access on demand training demos and sign up for training webinars on Empireblue.com, select Prior Authorization under the horizontal claims menu. Scroll down to the Interactive Care Reviewer (ICR) section

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

Empire's Interactive Care Reviewer (ICR) online tool is not currently available for the following:

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

Reversals

Utilization Management can reverse a pre-authorized treatment, service or procedure on retrospective review if:

- a) relevant medical information is materially different from information presented during the pre-authorization review; and
- b) information existed at the time of the pre-authorization review, but was withheld or not made available; and
- c) Empire was not aware of the existence of the information at the time of pre-authorization review; and
- d) had Empire been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Peer to Peer Review Process

Upon request from a treating practitioner, who is a licensed or certified professional providing medical care or behavioral healthcare services and directly involved in the Member's care/treatment plan. Anthem provides a clinical peer-to-peer conversation when an adverse medical necessity determination will be made or has been made regarding health care services for Members. The treating practitioner may offer additional information and/or further discuss his/her cases with a peer clinical reviewer. In compliance with accreditation standards, a practitioner or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

Quality of Care Incident

Providers and Facilities will notify Empire in the event there is a quality of care incident that involves a Member.

Audits/Records Requests

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

Case Management

Case Management assists Members to optimize the use of their benefits and available community resources to gain access to quality health care in all settings.

The Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs. Case Management programs are confidential and voluntary and are made available at no extra cost. These programs are provided by, or on behalf of and at the request of, health plan case management staff. These Case Management programs are separate from any Covered Services. If the Member meets program criteria and agrees to take part, we will help the Member meet identified health care needs. This is reached through contact and team work with the Member and/or the Member's chosen authorized representative, treating Physician(s), and other providers.

In addition, assistance may be provided in coordinating care with existing community-based programs and services. This may include giving information about external agencies and community-based programs and services.

AIM Specialty Health® (AIM)

AIM Specialty Health provides clinical solutions that drive appropriate, safe, and affordable care. Serving more than 50 million members across 50 states, D.C. and U.S. territories, AIM promotes optimal care through use of evidence-based clinical guidelines and real-time decision support for both providers and their patients. The AIM platform delivers significant cost-of-care savings across an expanding set of clinical domains, including radiology, cardiology, oncology, sleep medicine, musculoskeletal care, and genetic testing.

Visit AIM's program websites to find program information, clinical guidelines, interactive tutorials, worksheets & checklists, FAQs, and access to AIM **ProviderPortal_{SM}**

- Radiology: www.aimprovider.com/radiology
- Cardiology: www.aimprovider.com/cardiology
- Medical Oncology: www.cancercarequalityprogram.com
- Radiation Oncology: www.aimprovider.com/radoncology
- Genetic Testing: www.aimprovider.com/genetictesting
- Sleep: www.aimspecialtyhealth.com/gowebssleep
- Musculoskeletal: www.aimprovider.com/msk
- Surgical Procedures: www.aimproviders.com/surgicalprocedures
- Rehabilitation: www.aimproviders.com/rehabilitation

Submit Pre-certification/Pre-authorization requests to AIM

Ordering and servicing Providers may submit Pre-certification/Pre-authorization requests to AIM in one of the following ways:

- Access AIM **ProviderPortal_{SM}** directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Portal at availity.com
- Call the AIM Contact Center toll-free number: 1-877-430-2288, Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

OptiNet® Registration

The **OptiNet** Registration is an important tool that assists ordering providers in real-time decision support information to enable ordering providers to choose a high quality, low cost imaging providers for their patients. Servicing providers need to complete the **OptiNet** Registration online.

To access the **OptiNet** Registration:

- Access AIM **ProviderPortal** directly at providerportal.com.
 - You may also access AIM via the Availity Portal at availity.com
- Once logged into AIM, from the **My Homepage** screen, choose **Access Your OptiNet Registration**.
- Select the **Registration Type**, and choose the **Access Your OptiNet Registration** button.
- Complete requested information.

The registration does not need to be completed in one sitting. Data can be saved as you proceed through the registration. Once the registration has been submitted, a score card will be produced. The score for the Facility will be presented to the ordering Provider when the particular Facility is selected as a place of service which drives Ordering Provider Decision Support.

For technical questions, contact AIM **ProviderPortal** Web Support at 800-252-2021. For any other questions, contact your Empire Network Management Consultant.

Notification or Precertification Requirements

For HMO-Based Products

For hospital services, if Medical Management is not notified within the required time frames, we will deny payment for the days of service prior to the date of notification. The Medical Management Department will conduct a medical review based on medical necessity criteria only from the date that notification of the hospital admission is received, if the patient is still in the hospital, or for outpatient services, the date notification of services is received. If the patient has already been discharged or outpatient services terminated at the time of the notification, Medical Management will not review the services or admission and the claim will be denied.

For other provider services, as referenced in the Directory of Services, providers are required to precertify services for HMO-based products. Failure to obtain precertification for services will result in a denial of payment to the provider.

For PPO, EPO and Indemnity Products

Except as expressly stated in the member's health benefit plan on empireblue.com the responsibility of precertification for PPO, EPO and Indemnity products is placed on the member, based on the terms of the member's health benefit plan. If the member fails to notify Medical Management for a service requiring precertification, the service will either:

- a. Be denied if upon retrospective review, the service is determined to be not medically necessary or investigational. In such instances however, pursuant to the participating provider contract, the provider cannot balance bill the covered member unless a waiver is signed by the covered member in advance OR
- b. The covered member will be subject to a monetary penalty specific to his or her health benefit plan if the covered service is medically necessary. If we subsequently deny a claim for lack of medical necessity upon retrospective review and a waiver has not been signed by the covered member, you will have the right to appeal.

We encourage you to contact us on behalf of the member to precertify services where required.

Precertification Overview

Precertification Review Process

When you call us at the toll-free number listed on the back of the member's identification card, the service representative will request the following information:

- Member's and/or patient's identification number
- Patient's name, address and date of birth
- Scheduled/actual date of admission
- Type of admission (scheduled or emergent)
- Attending physician's name and telephone number
- Primary care physician's (PCP) name and telephone number (where applicable)
- Clinical Information for the purpose of assessing medical necessity

Once this information is obtained, your call will be transferred to a Medical Management licensed Nurse who will review each request for medical appropriateness of services and setting. This review is based on nationally recognized criteria and Empire Medical Policy. For more information please see the Utilization Management section in this Provider Manual.

Emergency Services

Emergency services are not subject to prior approval, but the provider must notify the plan of the service according to notification requirements.

Emergency service shall mean those covered services provided in connection with an emergency condition. Emergency condition means a medical or behavioral condition, the onset which is sudden, that manifests itself with symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention could result in:

1. placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part of such person; or
4. serious disfigurement of such person.

To the extent the member is admitted, we require notification of all inpatient emergency admissions within forty eight hours of the admission. To comply with this requirement, call Empire's Medical Management Program at 1-800-982-8089. Select the option for precertification on the telephone menu selections. During non-business hours you will have an option to leave a voicemail message.

You may notify us of an emergency admission by submitting the information through Empire's Online Services. If you are not yet registered to use this service, please go to Empire's website, empireblue.com, and click on the Facilities tab. Doing so will provide a fast and dependable way to notify Empire of admissions without having to make a telephone call Empire's Facility Online Services is available 24/7, with the exception of brief periods when the website undergoes system maintenance.

Empire's Timeframes for UM Decision Making

Pre-Service Non-Urgent	Decision and notification to enrollee and provider by phone and in writing within three (3) business days of receipt of all necessary information.
Continued Stay	Decision and notification to enrollee and provider by phone and in writing within one (1) business day of receipt of all necessary clinical information or 72 hours, whichever is shorter.
Urgent	Decision and notification to enrollee and provider by phone and in writing within one (1) business day of all necessary clinical information or 72 hours whichever is shorter.
Home Care Request Following Inpatient Admission	Decision and notification to enrollee and provider by phone and in writing within one (1) business day of receipt of all necessary information. If the day after the request for services falls on a weekend or holiday, within seventy two (72) hours of receipt of necessary information.

Post-Service	Decision and written notification to enrollee and provider within thirty (30) calendar days of receipt of all necessary clinical information.
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Please note: failure of Empire to make a UM determination within the time periods above is deemed to be an adverse determination subject to appeal.

If you would like more information regarding our Medical Management Program, visit empireblue.com.

Continued Stay Review Process – Telephonic

Once we have approved an initial length of stay or outpatient service/treatment, the facility or provider will continue to work with the Empire Medical Management Department for approval of additional days or services. It is the provider or facility's responsibility to provide all necessary clinical information to Empire's Medical Management Department.

When a member has required an inpatient stay, the goal of our Medical Management Department is to support a treatment plan that provides optimum care in a cost-effective manner that result in the earliest possible successful discharge consistent with the patient's medical needs and reduces the likelihood of a readmission.

For members requiring outpatient services, the goal of our Medical Management Department is to support a treatment plan that provides the appropriate number of treatments in the most appropriate setting, resulting in the successful conclusion of services consistent with the patient's medical needs.

Licensed Nurses may contact you or your utilization review staff to gather clinical information to assess medical necessity for the member. The nurses utilize clinical information from the medical record, the hospital staff, and/or attending physician in conjunction with medical necessity criteria,, medical policies and clinical guidelines to coordinate a medically effective and efficient transition through the case management process.

If the clinical information provided does not meet the medical necessity criteria for approval of the requested service or treatment, the nurse reviewer will refer the case to a Medical Director (licensed physician) for his/her review.

A Medical Director will review the information provided and may discuss the case with the attending physician. If a determination is made that treatment or inpatient stay is not medically necessary, the attending physician, the facility and the patient or patient representative will be notified immediately of the decision not to certify.

Hospital Admissions and Use of the Last Approved Day (LAD) Report

To help better prioritize the management of facility utilization review resources pursuant to your Agreement, Empire's UM will fax a Last Approved Day (LAD) Report to participating facilities on a daily basis. This report is faxed by 7:00 a.m., Monday – Sunday to the hospital's UR office to assist in the identification of Empire patients who require additional clinical information to approve coverage for the continued hospital stay. This report will not list members who are managed by third-party utilization vendors. The facility will need to contact the specific third-party utilization management vendor directly.

The report's format allows easy identification of patient's status in relation to our Medical

Management decisions from the previous day, current day, and the next review date. The report will reflect information received in our Medical Management System by end of business of the previous day. The column marked "Next Review Date" will identify those patients for whom additional clinical information is required to continue authorization for the hospital stay. This information must be communicated to our Medical Management Department via fax or phone before 3 p.m. of the day indicated in the next review date column or as soon as reasonably possible. If information needs to be communicated after 5 p.m. by the facility or provider, call Medical Management at 1-800-982-8089. During non-business hours you will have an option to leave a voicemail message or reach a nurse on weekend or holiday business hours.

If any of the information contained in the report is perceived to be incorrect, the facility shall contact our nurse reviewer staff at the toll-free number indicated in the column specific to that patient on the report.

The hospital staff is expected to amend the LAD report with a "Discharge Date" indicating actual date of discharge so that the member can be removed from the LAD report and included in the Discharge Summary Report faxed separately. The hospital will fax the marked LAD report to Empire at 1-800-464-5731. The hospital shall use good faith efforts to contact the admitting physician to obtain a discharge order when appropriate and Empire shall reasonably cooperate with such efforts.

An indication in the LAD report that a case has been "Certified" means that Empire has determined the services described are medically necessary for that date of service, based on the information provided. An indication of "DRG Notify upon D/C" means that Empire has determined the services described are medically necessary and that the DRG case rate is appropriate. Coverage for a particular date of service is NOT certified for any member not included on the LAD report for that date. It is the hospital's responsibility to notify Empire of any members not included on the LAD report. If authorization is denied, the denial will be indicated on the LAD report. In addition, Empire will provide a separate written notice of determination, consistent with applicable legal requirements.

Delay in Service Denials

If an Empire covered member has his or her inpatient hospital stay extended as a result of an unwarranted delay in the provision of hospital services due to the unavailability of any hospital equipment, personnel, facilities or test results we will not reimburse the facility or provider for the additional bed day(s). Some examples of service delays are equipment failure, operating room scheduling backlog, and unavailable test results.

Coverage denials based on the fact that there was, in our judgment, an unnecessary delay in providing a service do not involve a medical necessity determination. They are, therefore, not subject to appeal under our Medical Management Reconsideration and Appeals Process. The member must be held harmless and the facility or the physician may file a grievance under our grievance procedure.

Medical Necessity Denials

A written notice of an initial adverse determination (denial of coverage) will be sent to an Empire covered member and provider and includes:

1. The reasons for the determination including the clinical rationale, if any;
2. Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals;

3. Notice of the availability, upon request of the enrollee or enrollee's designee of the clinical review criteria relied upon to make the determination; and
4. What, if any additional information must be provided to, or obtained by, Empire in order to render an appeal decision, if requested.

Reconsideration and Medical Director Availability

Empire's medical directors are available to discuss medical necessity denial decisions with health care providers. To speak to a medical director, refer to the written denial notification. It includes information regarding how to contact the medical director.

When an adverse determination is rendered without an opportunity for the ordering physician to discuss the case with a Medical Director, the ordering health care providers have the right to request a reconsideration. Reconsiderations (peer to peer conversations) are completed within one business day of receipt of the request and are between the enrollee's health care providers and the clinical peer reviewer (Medical Director) making the denial decision. If Empire upholds its determination that the services are not medically necessary after the reconsideration, Empire will issue a notice of that determination.

We will also ensure that an expedited appeal shall be reviewed by a peer reviewer other than the peer reviewer who rendered the adverse determination.

Discharge Planning

Discharge planning is part of the entire healthcare continuum. For this reason, it is initiated as soon as possible after the patient is admitted, or ideally, at the time of precertification. Discharge planning requires anticipating and/or coordinating resources for ongoing care. The role of the Medical Management Nurse as it pertains to the discharge planning is to:

- Identify opportunities to improve healthcare efficiency (from quality and/or cost standpoint)
- Discuss the plan of care with the patient's physician
- Refer the treatment plan to our Medical Director for additional review whenever indicated
- Identify strategies for more cost-effective use of patient healthcare resources, consistent with quality care in the most appropriate setting
- Identify patients for additional case management opportunities by reviewing benefit options and discharge plans with the potential for alternative levels of care

Please contact the Medical Management Nurse as soon as discharge needs are known.

Individualized Care Management Program

Care management is a collaborative process used to develop individualized care plans to help optimize an individual members' health care coordination and outcome across the care continuum. Working directly with you, the healthcare provider treating physician, our member and his or her family, our registered nurses can assist you by educating the member regarding their options and help them access the covered services you have recommended as appropriate to meet their individual health needs. In partnership with you, we intend to promote quality outcomes and optimize use of health care benefits.

Our goal is to reach as many members as possible with complex medical conditions that are experiencing challenges with access to care or difficulty managing their disease process. We need your

assistance in identifying members who are appropriate for this program and your cooperation with the Empire clinicians who will work directly with you to assist in successfully implementing your plan of care to manage the member's medical condition and help to minimize re-admissions or other acute /urgent situations.

Examples of Care Management at work:

- A member that lives alone is unable to get to your office due to lack of transportation and lack of family support. The benefit plan does not cover an ambulette, but we can connect this member to local community groups or city services such as, Access-A-Ride, who will provide safe and low cost (either free or minimal payment) options. This is an example of how we can assist you in providing the high quality care we all desire and avoid the unnecessary use of the emergency room.
- An oncology patient, who is depressed because of their condition, isn't eating properly and feels isolated. With your assistance and encouragement, we refer the member to support groups hosted by the American Cancer Society. The member attends the meeting and vents expresses their fears, sees that they are not alone and learns how others are struggling, but succeeding in maintaining a good nutritional status. After this interaction, the member agrees to receive Meals on Wheels and other support to maintain their nutritional status.

Who qualifies for our Care Management Program?

This voluntary program covers most of Empire's local business. There is no additional cost to the member. Members of certain groups, such as our hospital only contracts, (this includes New York City and New York State enrollees), State and Federal Health Benefit program beneficiaries, are not eligible.

Who can be referred?

Any eligible member can be referred. Conditions which commonly benefit from Care Management are listed below:

Brain Injury with deficit

- Severe Burns
- Select Cancer Diagnosis
 - Female Breast, Uterus, Ovary, Prostate, Bladder, Kidney, Urinary Organs, Brain, Thyroid, Respiratory or Digestive System, Secondary Neoplasm, Hodgkin Disease, Lymphoid Disease, Multiple Myeloma and Myeloid Leukemia
- Benign Brain Tumor
- Congenital Abnormalities ages 1-12
- Complications of Surgery
- Endotracheal Intubation/ Tracheostomy/ Ventilator Dependency
- Non-Healing Surgical Wounds
- Multiple Trauma Spinal Cord Injuries
- Members identified as high risk
- Members with care giver issues
- Members with recurrent readmissions
- Continuation of care requests
- Members you think are non-compliant with their medication

To refer a member to Empire's Care Management Program please call us at 1-800-563-5909 or email us at ECM-NY@Wellpoint.com.

Specialty Care Center and PCP Specialist Requests

A referral to a specialty care center and/or a specialist as a PCP may be requested when:

1. An enrollee is diagnosed with a life-threatening condition or disease or degenerative, disabling condition or disease
AND
2. Due to the condition/disease as above, the enrollee requires specialized medical care over a prolonged period of time.

Empire's Medical Management nurses will request documentation of the treatment plan, and seek approval of the PCP and specialist before determining if the referral will be approved by Empire.

Empire's Medical Management Department will assess a request for a specific specialty care center or specialist PCP, or can provide names of specialty care centers or specialist PCP's appropriate for the enrollee's condition.

If you need to request a referral to a specialty care center or request a specialist PCP, contact Empire's Medical Management Department at 1-800-441-2411, 8:30 a.m. to 5:00 p.m. EST, Monday – Friday.

Standard Appeals

If Empire Medical Management determines that an admission, extension of a continued stay, or some other health care service is not medically necessary, the health care provider, the member or his/her authorized representative may request reconsideration or appeal an adverse determination in the following manner.

The following can be appealed internally with Empire:

- Our initial adverse determination (Level 1 appeal)
- Our final adverse determination following a standard Level 1 appeal if available under the health benefit plan (Level 2 appeal)

The following can be reconsidered:

- An initial pre-service or concurrent denial.

Services that have already been provided are not subject to reconsideration.

A healthcare provider may file an appeal for a retrospective denial.

Depending on the health benefit plan, Empire offers either one or two levels of standard appeal.

Empire offers two levels of standard appeal. Appeals should be accompanied by a letter stating why the decision is being appealed and why you feel the decision should be overturned. Also include the information necessary to review it, such as the medical record. Appeals will be acknowledged within fifteen (15) days of receipt. If additional information is necessary to conduct a standard internal appeal, Empire will notify you, the provider, within fifteen (15) days of receipt of appeal to identify and request the necessary information. In the event that only a portion of the requested necessary information is received, Empire shall request the missing information, in writing, within five (5) business days of the

partial information receipt. Empire will notify the member, the member's designee and the provider in writing of the appeal determination within two (2) business days of the decision.

An appeal is initiated by calling or writing to the Empire Medical Management Appeals Department at 1-800-634-5605, 8:30 a.m. to 5:00 p.m. EST, Monday – Friday, or by writing to:

Empire BlueCross BlueShield
Attention: Appeals Department
PO Box 1407
Church Street Station
New York, New York 10008-1407

Level 1 Appeals must be initiated within one hundred eighty (180) calendar days of our initial decision. Appeals filed after that date will not be considered, and you will receive a letter stating that the opportunity to file an appeal has been exhausted. The appeal should be accompanied by a letter stating why the determination is being appealed and why it should be overturned, as well as the information necessary to review it, such as the medical record.

If we make a decision favorable to the person filing the appeal, written notification is sent stating that the initial denial decision has been reversed. If we make a final adverse determination upholding our prior decision, we will provide written notification that will include:

- The basis and clinical rationale upon which the appeal determination is based
- The words “final adverse determination”
- The health service that was denied, including the facility/provider and/or the developer/manufacturer of service as available.
- Information and rights regarding filing a request for a Level 2 appeal to Empire (if available).
- A clear statement in bold that the member or member's authorized representative has four months from the final adverse determination to request an external appeal; or for provider initiated appeals (retrospective services), a statement that the provider has forty five (45) days from the final adverse determination to request an external appeal
- A statement that choosing a 2nd level of internal appeal, if available under the benefit plan, may cause time to file external appeal to expire.
- Statement that member may be eligible for external appeal and timeframes for external appeal
- Standard description of external appeals process is attached
- Empire Appeals contact and telephone number
- The type of coverage the appellant is enrolled in
- The name and address of the UR agent including a contact person and telephone number

Failure by Empire to make a determination within the applicable time frames set forth in NYS Public Health Law and Insurance Law Sections 4904.5 and 4905(e), respectively, shall be deemed to be a reversal of Empire's adverse determination. Notwithstanding the foregoing, the aforementioned requirement as far as the reversal of an adverse determination shall only apply to insured benefit plans that are regulated by New York law. .

Note: The enrollee and Empire may jointly agree to waive the internal appeal process; if this occurs, Empire will provide a written letter with information regarding the process for filing an external appeal to the enrollee within twenty four (24) hours of the agreement to waive Empire's internal appeal

process.

Expedited Appeals

The health care provider, member or his/her authorized representative may request an urgent/expedited appeal to be implemented when the denial of coverage involves any of the following:

- Cases involving continued or extended healthcare services, procedures or treatments (including home health care services following an inpatient hospital admission);
- Requests for additional services for a patient undergoing a continuing course of treatment
- Any case in which the member's physician or healthcare provider believes an immediate appeal is warranted.

Note: There is only one (1) level of expedited appeal. Expedited appeals that are not resolved to the satisfaction of the appealing party may be further appealed via the standard appeal process as a Level 2 appeal or through the external appeal process. Retrospective appeals are not eligible to be expedited. If sufficient documentation to conduct the expedited appeal is not provided, the Empire Appeals Department will immediately notify the member and the member's health care provider by telephone or facsimile to identify and request the necessary information followed by written notification.

Written notice of final adverse determinations concerning an expedited UR appeal shall be transmitted to members within twenty four (24) hours of rendering the determination.

Expedited appeals will be decided within 2 business days of receipt of necessary information. Written notice of final adverse determination concerning an expedited appeal shall be transmitted to the member within 24 hours of rendering the determination. Expedited appeal outcomes are also telephonically relayed to the person filing the appeal.

We will provide reasonable access to a Medical Director within one (1) business day of receiving notice of the request for an expedited appeal.

An Expedited Appeal is initiated by calling or writing to the Empire Medical Management Appeals Department at 1-800- 634-5605, 8:30 a.m. to 5:00 p.m. EST, Monday – Friday, or by writing to:

Empire BlueCross BlueShield
Attention: Appeals Department
PO Box 1407
Church Street Station
New York, New York 10008-1407

Summary of Appeal Timeframes

For Empire's benefit plans with one level of internal appeal available:

Level of Appeal	Type of Appeal	Time frame to request appeal	Time frame to respond
Level 1	Expedited	180 calendar days from the initial denial	2 business days of receipt of necessary information or 72 hours when additional information requested

Level 1	Pre-service	180 calendar days from the initial denial	30 calendar days
Level 1	Post-service	180 calendar days from the initial denial	60 calendar days

For Empire's benefit plans with two levels of internal appeal available:

Level of Appeal	Type of Appeal	Time frame to request appeal	Time frame to respond
Level 1	Expedited	180 calendar days from the initial denial	2 business days of receipt of necessary information or 72 hours when additional information requested
Level 1	Pre-service	180 calendar days from the initial denial	15 calendar days
Level 1	Post-service	180 calendar days from the initial denial	30 calendar days
Level 2	Expedited	N/A	N/A
Level 2	Pre-service	60 business days from the first level appeal denial letter	15 calendar days
Level 2	Post-service	60 business days from the first level appeal denial letter	30 calendar days

External Reviews

Based on applicable New York State Insurance and Public Health Law, if services in whole or in part, were denied based on medical necessity or a determination that they are experimental or investigational, subsequent to an appeal you may have the right to an external review. You can initiate an external review using the form Empire will send you when our final adverse determination is made. An enrollee, the enrollee's designee and, in connection with concurrent and retrospective adverse determinations, an enrollee's health care provider shall have the right to request an external review.

An external appeal may be filed:

- When the enrollee has had coverage of a health care service which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care services is not medically necessary and Empire has rendered a final adverse determination with respect to such health care services or both Empire and the enrollee have jointly agreed to waive any internal appeal.
- When the enrollee has had coverage of a health care service denied on the basis that such service is experimental or investigational and the denial has been upheld on appeal or both Empire and the member have jointly agreed to waive any internal appeal and the member's attending physician has certified that the enrollee has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by Empire or (c) for which there exists a clinical trial and the

enrollee's attending, physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life threatening or disabling condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of PHL 4900 (5)(b)(B), that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. Any physician certification provided shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

Note: The enrollee and Empire may jointly agree to waive the internal appeal process; if this occurs Empire will provide a written letter with information regarding filing an external appeal to member within twenty four (24) hours of the agreement to waive Empire's internal appeal process.

An external appeal must be submitted within one hundred and twenty (120) days upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested. **If a member chooses to request a second level internal appeal, the time may expire for the member to request an external appeal.**

Predetermination Overview

Empire has established a predetermination process for services where precertification is not required and you can confirm in advance of providing the service whether the service meets medical policy criteria. Services available for predetermination include bariatric surgeries, spinal surgeries and specialty pharmacy drugs. The predetermination enables the member and physician or other healthcare provider to verify the service meets our medical necessity criteria before delivering the care. Although a predetermination is not required, we encourage physicians or other healthcare providers to obtain one prior to performing any of these procedures.

When a predetermination is not obtained prior to the procedure, the claim for the service will be reviewed for medical necessity on a retrospective basis. In cases when an adverse determination is issued, you and the member may access available appeal levels before delivery of the service. The medical necessity criterion is available online for your review at [empireblue.com](https://www.empireblue.com).

Empire as Secondary Payor

If Empire is the secondary payor, it will not require the hospital or the member to obtain precertification from Empire, and will not deny or reduce amounts that would otherwise be owed because a provider or subscriber did not comply with its administrative or utilization review requirements, including notification, precertification, or concurrent review. However, Empire will not be bound by the primary Payor's decisions concerning the medical necessity of a service.

Member Quality of Care (“QOC”)/Quality of Service (“QOS”) Investigations

Overview

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

Quality of care grievances and PQIs are processed by clinical associates. Medical records and a response from the Provider and/or Facility are requested. If the clinical associate determines the case is a non-issue with no identifiable quality issue, the clinical associate may assign a severity level C-0. A clinical associate may also assign a severity level rating of C-1 if the case meets the criteria for a known complication. A clinical associate may issue a C-3 rating for a Provider’s or Facility’s failure to submit requested information. Otherwise, the clinical associate will send a case summary to the Medical Director for review (i.e., First Level Peer Review). The case summary will include a list of previous severity levels assigned to the involved Provider and/or Facility on a rolling 12-month basis. If there are no previous severity levels, this will be documented. The Medical Director will select a specialty matched reviewer to evaluate the case, as appropriate. Upon completion of the review, the Medical Director makes a final determination and assigns a severity level for tracking and trending purposes. Upon completion of First Level Peer Review, if the case is a Member grievance, the Member is sent a resolution letter within thirty (30) calendar days of Empire’s receipt of the grievance. The Member is informed that peer review statutes do not permit disclosure of the details and outcome of the quality investigation. In addition, the clinical associate will send a letter to the Provider and/or Facility explaining the outcome of the review and the severity level assigned.

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

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

Providers and Facilities have a contractual obligation to actively cooperate with any investigation. When a Member alerts Empire to a quality concern regarding the care they received, Empire has an obligation to thoroughly investigate that allegation by reviewing all relevant materials including any internal investigation and their outcomes done by the impacted Providers and/or Facility. This requirement is in the Provider and Facility Agreements and, as a business associate, Empire has a right to that information.

Corrective Action Plans (“CAP”)

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

Reporting

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

Severity Levels for Quality Assurance

Quality of Care		
Level	Points Assigned	Description
C-0	0	No quality of care issue found to exist.
C-1	0	Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern.
C-2	5	Communication, administrative, or documentation issue that adversely affected the care rendered.
C-3	5	Failure of a practitioner/provider to respond to a member grievance regarding a clinical issue despite two requests per internal guidelines.
C-4	10	Mild deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be mildly beneath the standard of care.
C-5	15	Moderate deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be moderately beneath the standard of care.
C-6	25	Significant deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be significantly beneath the standard of care.

Quality of Service		
Level	Points Assigned	Description
S-0	0	No quality of service or administrative issue found to exist.
S-1	0	Member grievances regarding practitioner's office: physical accessibility, physical appearance, and adequacy of the waiting-room and examining-room space.
S-2	5	Communication, administrative, or documentation issue with no adverse medical effect on member.
S-3	5	Failure of a practitioner/provider to respond to a member grievance despite two requests per internal guidelines.
S-4	10	Confirmed discrimination, confirmed HIPAA violation, confirmed confidentiality and/or privacy issue.

Trend Threshold for Analysis

Quality of Care and Service Trend Parameters

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

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

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

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

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

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

Credentialing

Empire's Discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Empire's discretion in any way to amend, change or suspend any aspect Empire's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners who seek to provide healthcare services to our Members. Empire further retains the right to approve, suspend, or terminate individual physicians and health care professional, and sites in those instances where it has delegated credentialing decision making.

Empire will complete review of the health care professional's application within 60 days of receiving a completed application and notify the health care professional as to (1) whether he or she is credentialed; or (2) whether additional time is necessary to make a determination because of the failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, Empire shall make every effort to obtain such

information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

Credentialing Scope

Empire credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractor
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic Counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dieticians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Abuse Practitioners

Empire credentials the following Health Delivery Organizations ("HDOs"):

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings, including:

- Adult Family Care/Foster Care Homes
- Ambulatory Detox
- Community Mental Health Centers (“CMHC”)
- Crisis Stabilization Units
- Intensive Family Intervention Services
- Intensive Outpatient – Mental Health and/or Substance Abuse
- Methadone Maintenance Clinics
- Outpatient Mental Health Clinics
- Outpatient Substance Abuse Clinics
- Partial Hospitalization – Mental Health and/or Substance Abuse
- Residential Treatment Centers (“RTC”) – Psychiatric and/or Substance Abuse
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following Health Delivery Organizations (HDO’s) are not subject to professional conduct and competence review under The Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification)
- Portable x-ray Suppliers (FDA Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

Credentials Committee

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

The CC will meet at least once every forty-five (45) calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (“MA”) is represented, a second vice-chair representing MA may be designated. The chair must be a state or regional lead medical director, or an Empire medical director designee and the vice-chair must be a lead medical officer or an Empire medical director designee, for that line of business not represented by the chair. In states or regions where only one (1) line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five(5), but no more than ten (10) external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one (1) to two (2) other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair’s discretion. At least two (2) of the physician

committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or terminate a practitioner from participation in one (1) or more Networks or Plan Programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are Network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. In particular, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulating agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Empire's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. On request, the practitioner will be provided with the status of their credentialing or recredentialing application.

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

Nondiscrimination Policy

Empire will not discriminate against any applicant for participation in its programs or provider Network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned

herein. Additionally, Empire will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process.

Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Anthem will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Anthem will take appropriate action(s) to track and eliminate those practices.

Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Empire when applying for initial participation in one (1) or more of Empire's Networks or Plan Programs. For practitioners, the Council for Affordable Quality Healthcare ("CAQH") ProView system is utilized. To learn more about CAQH, visit their web site at www.CAQH.org.

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

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

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state controlled substance registrations <ul style="list-style-type: none"> The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.

Verification Element
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Recredentialing

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

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

Health Delivery Organizations

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

that HDO.

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

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

Ongoing Sanction Monitoring

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

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

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals Process

Empire has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one (1) or more of Empire’s Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Empire may wish to terminate practitioners or HDOs. Empire also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Empire’s Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (“NPDB”). Additionally, Empire will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It Empire’s intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner’s or HDO’s participation in one (1) or more of Empire’s Networks or Plan Programs and those denials of

request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Empire's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting Requirements

When Empire takes a professional review action with respect to a practitioner's or HDO's participation in one (1) or more of its Networks or Plan Programs, Empire may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Empire Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:

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

- A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHB; and
- B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members; and
- C. Possess a current, valid, and unrestricted Drug Enforcement Agency ("DEA") and/or Controlled Dangerous Substances ("CDS") registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one (1) state must have a DEA/CDS registration for each state.
- D. Meet the education and training criteria as required Empire.

In addition, Initial applicants must meet one of the following board certification criteria, as applicable. In order to be considered for participation, Empire reserves the right, in its reasonable discretion, to waive the board certification or alternative requirement when Empire determines that there are extenuating or special circumstances that warrant the waiver of such requirement.

- A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties ("ABMS"), American Osteopathic Association ("AOA"), Royal College of Physicians and Surgeons of Canada ("RCPSC"), College of Family Physicians of Canada ("CFPC"), American Board of Foot and Ankle Surgery ("ABFAS"), American Board of Podiatric Medicine ("ABPM"), or

American Board of Oral and Maxillofacial Surgery ("ABOMS")) in the clinical discipline for which they are applying.

- B. If not board certified, MDs and DOs will be granted five (5) years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
- C. If not board certified, DPMs will be granted five (5) years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven (7) years after completion of their residency to meet this requirement for ABFAS
- D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

- 1. As alternatives to board certification, MDs and DOs meeting any one (1) of the following criteria will be viewed as meeting the education, training and certification requirement:

- a. Previous board certification (as defined by one (1) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of ten (10) consecutive years of clinical practice. or
- b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. or
- c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching Facility in Empire's Network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

- 2. Practitioners meeting one (1) of these three (3) alternative criteria (a, b, c) will be viewed as meeting all Empire education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. The above alternatives are subject to Empire review and approval.

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

II. Criteria for Selecting Practitioners

- A. New Applicants (Credentialing)

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

Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

- a. It can be verified that this application is pending.
- b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
- c. The applicant agrees to notify Empire upon receipt of the required DEA/CDS registration.
- d. Empire will verify the appropriate DEA/CDS registration via standard sources.
 - i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar day timeframe will result in termination from the Network.
 - ii. Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Empire's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:
 - (a) It can be verified that the applicant's application is pending; and
 - (b) The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and

- (c) The applicant agrees to notify Empire upon receipt of the required DEA registration; and
 - (d) Empire will verify the appropriate DEA/CDS registration via standard sources; and
 - (e) The applicant agrees that failure to provide the appropriate DEA registration within a ninety (90) day timeframe will result in termination from the network.
- iii. Office-based practitioners who voluntarily choose to have a DEA/CDS registration that does not include all Controlled Substance Schedules (for example, Schedule, II, III or IV), if that practitioner certifies the following:
 - (a) controlled substances from these Schedules are not prescribed within his/her scope of practice; and
 - (b) he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances from these Schedules should it be clinically appropriate; and
 - (c) DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.
- 10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
- 11. No history of or current use of illegal drugs or history of or current alcoholism;
- 12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
- 13. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable.
- 14. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence. A minimum of the past ten (10) years of malpractice case history is reviewed.
- 15. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Empire's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
- 16. No involuntary terminations from an HMO or PPO;
- 17. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
 - a. Investment or business interest in ancillary services, equipment or supplies;
 - b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - c. Voluntary surrender of state license related to relocation or nonuse of said license;
 - d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.

- e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
- f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
- g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
- h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

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

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

1. Licensed Clinical Social Workers ("LCSW") or other master level social work license type:
 - a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education ("CSWE") or the Canadian Association on Social Work Education ("CASWE")
 - b. Program must have been accredited within three (3) years of the time the practitioner graduated
 - c. Full accreditation is required, candidacy programs will not be considered and
 - d. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association ("APA") or be regionally accredited by the Council for Higher Education Accreditation ("CHEA"). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.
2. Licensed professional counselor ("LPC") and marriage and family therapist ("MFT") or other master level license type:
 - a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one (1) of the fields of study above.
 - b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
 - c. Graduate school must be accredited by one (1) of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs ("CACREP"), or Commission on Accreditation for Marriage and Family Therapy Education ("COAMFTE") listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.
 - d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be

- regionally accredited by the CHEA. A Practitioner with a doctoral degree in one (1) of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and;
- e. Licensure to practice independently.
3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
 - a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one (1) of the Regional Institutional Accrediting Bodies within three (3) years of the time of the practitioner's graduation.
 - b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
 - c. Certification by the American Nurses Association ("ANA") in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner and
 - d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.
 4. Clinical Psychologists:
 - a. Valid state clinical psychologist license
 - b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner's graduation
 - c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a diplomat of the American Board of Professional Psychology and
 - d. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.
 5. Clinical Neuropsychologist:
 - a. Must meet all the criteria for a clinical psychologist listed in B.4 above and be Board certified by either the American Board of Professional Neuropsychology ("ABPN") or American Board of Clinical Neuropsychology ("ABCN")
 - b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered and
 - c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have

appropriate training and/or experience in neuropsychology as evidenced by one (1) or more of the following:

- i Transcript of applicable pre-doctoral training, OR
- ii Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate), OR
- iii Letters from supervisors in clinical neuropsychology (including number of hours per week), or
- iv Minimum of five (5) years experience practicing neuropsychology at least ten (10) hours per week.

6. Licensed Psychoanalysts:

- a. Applies only to practitioners in states that license psychoanalysts.
- b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
- c. Practitioner must possess a valid psychoanalysis state license.
 - i. Practitioner shall possess a master's or higher degree from a program accredited by one (1) of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within three (3) years of the time the practitioner graduates.
 - ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
 - a. A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.
 - b. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
 - c. Meet examination requirements for licensure as determined by the licensing state.

C.. Additional Participation Criteria and Exceptions for Nurse Practitioners, Certified Nurse Midwives, Physicians Assistants (Non Physician) Credentialing.

- Process, requirements and Verification – Nurse Practitioners:

- a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
- c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Empire procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
- e. All NP applicants will be certified in the area which reflects their scope of practice by any one (1) of the following:
 - i. Certification program of the American Nurse Credentialing Center (www.nursecredentialing.org), a subsidiary of the American Nursing Association (http://www.nursingcertification.org/exam_programs.htm);
 - ii. American Academy of Nurse Practitioners – Certification Program (www.aanpcertification.org);
 - iii. National Certification Corporation (<http://www.nccwebsite.org>);
 - iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) (<http://www.pncb.org/ptistore/control/exams/ac/progs>);
 - v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY (<http://oncc.org>); or
 - vi. American Association of Critical Care Nurses (<https://www.aacn.org/certification/verify-certification>) ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Empire is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

- f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
 - g. The NP applicant will undergo the standard credentialing processes outlined in Empire's Credentialing Policies ("Credentialing Policies" or Credentialing Policy). NPs are subject to all the requirements outlined in these Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
 - h. Upon completion of the credentialing process, the NP may be listed in Empire's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
 - i. NPs will be clearly identified as such:
 - i. On the credentialing file;
 - ii. At presentation to the CC; and
 - iii. Upon notification to Network Services and to the provider database.
- Process, Requirements and Verifications – Certified Nurse Midwives:
 - a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
 - b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
 - c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
 - d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Empire procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
 - e. All CNM applicants will be certified by either:
 - i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or

- ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.
This certification must be active and primary source verified. If the state licensing board primary source verifies one (1) of these certifications as a requirement for licensure, additional verification by Empire is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
- f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
- g. The CNM applicant will undergo the standard credentialing process outlined in Empire's Credentialing Policies. CNMs are subject to all the requirements of these Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
- h. Upon completion of the credentialing process, the CNM may be listed in Empire's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- i. CNMs will be clearly identified as such:
 - i. On the credentialing file;
 - ii. At presentation to the CC; and
 - iii. Upon notification to network services and to the provider database.
- Process, Requirements and Verifications – Physician's Assistants (PA):
 - a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
 - b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
 - c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

- d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Empire procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
- e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Empire is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to geographic Credentialing Policy #8 as adopted or amended by each Anthem Health Plan and submitted for individual review by the CC.
- f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
- g. The PA applicant will undergo the standard credentialing process outlined in Empire's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years (3), and continuous sanction and performance monitoring upon participation in the network.
- h. Upon completion of the credentialing process, the PA may be listed in Empire provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- i. PA's will be clearly identified such:
 - i. On the credentialing file;
 - ii. At presentation to the CC; and
 - iii. Upon notification to Network Services and to the provider database.

D. Currently Participating Applicants (Recredentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Empire's programs or provider Network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Empire's other credentialed provider Network(s).
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;

6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
 - b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - c. Voluntary surrender of state license related to relocation or nonuse of said license;
 - d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
 - e. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
 - f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
 - g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
 - h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
16. No quality improvement data or other performance data including complaints above the set threshold.
17. Recredentialed at least every three (3) years to assess the practitioner's continued compliance with Empire standards.

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

Note: the CC will individually review any credentialed Network practitioners and HDOs that do

not meet one (1) or more of the criteria for recredentialing.

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Empire may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past thirty-six (36) months. If a HDO has satellite facilities that follow the same policy and procedures, Empire may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Empire standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three (3) years to assess the HDO's continued compliance with Empire standards.

A. General Criteria for HDOs:

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

B. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Empire Approved Accrediting Agent(s)

Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM, DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Skilled Nursing Facilities/Nursing Homes	BOC INT'L, CARF, TJC

Behavioral Health

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NIAHO, TJC, HFAP
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAH, CARF, CHAP, COA, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	DNV/NIAHO, HFAP, TJC, CTEAM
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Abuse Clinics	CARF, TJC, COA

Quality Improvement Program

Quality Improvement Program Overview

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

- The QI Program Description establishes QI Program governance, scope, goals, objectives, structure, and responsibilities encompassing the quality of medical and behavioral health care and services provided to Members.

- The QI Work Plan is developed and implemented which reflects ongoing progress made on QI activities during the year. The QI Work Plan includes Empire's approach to patient safety for Members and improving medical and behavioral health care: quality of clinical care, safety of clinical care, quality of service and Members' experience.
- The QI Evaluation assesses outcomes of Empire's medical and behavioral health care programs, processes, activities and performance in the quality and safety of clinical care and service. The QI Evaluation also evaluates how the QI Program goals and objectives were met.

Goals and Objectives

The following QI Program goals and objectives support Empire's vision and values, promote continuous improvement in quality care, patient safety for Members and quality of service to Members, Providers and Facilities:

- To develop and maintain a well-integrated system to continuously identify, measure, assess, and improve clinical and service quality outcomes through standardized and collaborative activities.
- To respond to the needs and expectations of internal and external customers by evaluating performance and taking action relative to meeting those needs and expectations, including compliance with regulatory and accreditation requirements, policies and procedures.
- To promote processes that help reduce medical errors and improve patient safety for Members by implementing Member-focused, Provider and safety initiatives.
- To identify and promote educational opportunities for Members, medical and behavioral health care Providers.
- For multicultural health strategies – to improve the health and health care of Empire's multicultural Members.
- To help maximize health status, improve health outcomes and reduce health care costs of Members through effective Case Management ("CM") and Disease Management ("DM") programs addressing complex care needs.

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

Quality and Safety of Clinical Care

- *Chronic Disease and Prevention:* Empire focuses on Member and/or Provider/Facility outreach for chronic conditions like asthma, heart disease, diabetes, and Chronic Obstructive Pulmonary Disease ("COPD") and for preventive health services such as immunizations and cancer screenings. Improvements in these areas result in improved clinical measures such as HEDIS[®] (Healthcare Effectiveness Data and Information Set)¹.
- *Behavioral Health Case Management:* A program designed to provide a comprehensive and integrated approach to early identification, treatment, intensive case management and individualized recovery support for Members with complex behavioral health conditions who are at risk for negative outcomes and high costs.
 - *Community Health:* Empire has committed resources and worked with key entities to co-create community-based health initiatives to address public health concerns and societal problems including behavioral health/substance abuse disorder, cancer, diabetes and maternal and child health and addressing health disparities..

- *Disease Management:* The ConditionCare program is designed to help maximize health status, improve health outcomes, and reduce health care costs of Members diagnosed with Asthma (pediatric and adult), Diabetes (type 1 and type 2, pediatric and adult), Coronary Artery Disease (“CAD”), Heart Failure (“HF”) and COPD. The DM program was created and developed based on recent versions of nationally accepted evidence-based Clinical Practice Guidelines (“CPGs”). These guidelines are reviewed at least every two years, and program interventions and protocols are updated accordingly.
- *Health and Wellness:* Programs offer a seamless integration of preventive care, wellness, care management coordination services and online and mobile tools. The programs are clinically driven and designed to help Members better manage individual health and make more informed health care decisions. Programs include: MyHealth Coach (“MHC”), MyHealth Advantage (“MHA”), Neonatal Intensive Care Unit (“NICU”) program, Worksite Wellness, Healthy Lifestyles (“HL”) and Healthwise® Knowledge Base (“HWKB”).

Service Quality

Empire periodically surveys its Members, monitors the quality of care and service of network Providers and strives to provide excellent service to Members, Providers and Facilities. Empire actively analyzes business processes, trends, identifies and takes action on opportunities to improve the Member, Provider and Facility experience, recommending appropriate activities to address root causes.

Patient Safety for Members

Patient safety is the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum (World Health Organization, 2019). The overall goal is to build a safer health system and decrease the occurrence of preventable adverse events and hospital acquired conditions by creating a safety culture that improves the delivery of health care and health outcomes and raises awareness of patient safety related issues by providing tools and education for Members regarding patient safety issues.

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

Member Rights and Responsibilities

The delivery of quality health care requires cooperation between Members, their Providers and Facilities and their health care benefit plans. One of the first steps is for Members, Providers and Facilities to understand member rights and responsibilities. Therefore, Empire has adopted a Members’ Rights and Responsibilities statement which can be accessed by going to empireblue.com/provider/

Select the **Provider** link at the top of the landing page. Select **Policies, Guidelines and Manuals** (under the Provider Resources column Scroll down and select the **Read about Member Rights** link under the **More Resources/Member Rights and Responsibilities** section, then choose the **What are my rights as a member** FAQ question Members or Providers who do not have access to the website can request copies by contacting Anthem. If Members need more information or would like to contact us, go to empireblue.com, and select **Contact Us** at the bottom of the page. Or Members can call the Member Services number, and Providers can call the Provider Services number on the back of the Member ID card.

Continuity and Coordination of Care

Empire encourages communication between all physicians, including primary care physicians (PCPs) and medical specialists, as well as other health care professionals who are involved in providing care to Empire Members. Please discuss the importance of this communication with each Member and make every reasonable attempt to elicit permission to coordinate care at the time treatment begins. HIPAA allows the exchange of information between Covered Entities for the purposes of Treatment, Payment and Health Care Operations.

The Empire QI Program is an ongoing and integrative program, which features a number of evaluative surveys and improvement activities designed to help ensure the continuity and coordination of care across physician and other health care professional sites, enhancing the quality, safety, and appropriateness of medical and behavioral health care services offered by Providers.

Continuity of Care/Transition of Care Program

This program is for Members when their Provider or Facility terminates from the network and new Members (meeting certain criteria) who have been participating in active treatment with a provider not within Empire's network.

Empire makes reasonable efforts to notify Members affected by the termination of a Provider or Facility according to contractual, regulatory and accreditation requirements and prior to the effective termination date. Empire also helps them select a new Provider or Facility.

Empire will work to facilitate the Continuity of Care/Transition of Care (COC/TOC) when Members, or their covered dependents with qualifying conditions, need assistance in transitioning to in-network Providers or Facilities. The goal of this process is to minimize service interruption and to assist in coordinating a safe transition of care. Completion of Covered Services may be allowed at an in-network benefit and reimbursement level with an out-of-network provider for a period of time, according to contractual, regulatory and accreditation requirements, when necessary to complete a course of treatment and to arrange for a safe transfer to an in-network Provider or Facility. Completion of Covered Services by a Provider or Facility whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity will not be facilitated.

Members may contact Customer Care to get information on Continuity of Care/Transition of Care.

Empire's Medical Management will approve continued care depending upon the benefit plan if the member meets the conditions described below and the provider meets the outlined requirements:

When a member's PCP or specialist terminates from the plan and the member is receiving an ongoing course of treatment for a disabling, degenerative or life threatening condition, he or she may continue to receive covered treatment from the terminated provider for up to 90 days from the date the member received notice of the termination. After that, the member must choose a network provider. This policy also applies to pregnant women in the second or third trimester when they receive notice of their provider's termination from the plan. The provider may give covered services, including the delivery and postpartum care directly related to the delivery.

Your participation agreement obligates you to continue to treat patients who are receiving a course of treatment from you at the time your participation terminates. Specifically, you are required to continue treating these patients and to continue accepting the rates applicable under your participation agreement, until the completion of their course of treatment or appropriate transfer to another participating provider. This obligation applies to all products. In no such event shall a physician abandon any patient for any reason.

In all such cases, Empire requires that the non-network provider:

- Meet Empire's Quality Assurance standards
- Agree to accept as payment in full those payment rates that were in effect when he or she was a participating network provider
- Agree to provide Empire with all necessary information related to the care given to the member
- Agree to adhere to all relevant Empire policies and procedures, including the rules regarding referrals and precertification of certain services.

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

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

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

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

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

Annual meetings are held with participating hospitals from across the country, offering participants an opportunity to share feedback regarding new metrics and initiatives. Additionally, a National Advisory Panel on Value Solutions ("NAPVS") was established in 2009 to provide input during the scorecard development process. The NAPVS is made up of patient safety and quality leaders from health systems and academic medical centers from across the country and offers valuable advice and guidance as new measures are evaluated for inclusion in the program.

Participating hospitals are required to provide Empire with data on measures outlined in the Q-HIP Manual. Q-HIP measures are based on commonly accepted indicators of hospitals' quality of care.

Participating hospitals will receive a copy of their individual scorecard which shows their performance on the Q-HIP measures.

Performance Data

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

- **Reward Programs** – Pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie Provider or Facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to total cost of care shared savings/risk programs, enhanced fee schedules and episode bundled payment arrangements.
- **Recognition Programs** – Programs designed to transparently identify high value Providers and Facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

Patient Center Primary Care Program (PCPC)

Today, the fundamental issue in health care is how to improve quality while reducing costs. Much of health care delivery is fragmented and episodic with no clear way to improve patient health. We believe the doctor-patient relationship is the most important in health care. It is key to improving quality and outcomes and, subsequently, lowering costs. Therefore, we are making a significant investment in primary care to help doctors do what they do best: manage all aspects of their patients' care.

Our new Patient Centered Primary Care Program will increase revenue opportunities for primary care physicians, enhance information sharing, and provide care management support from Empire clinical staff.

For more information on PCPC, please contact your Network Management Consultant or visit our website at empireblue.com.

Overview of HEDIS

HEDIS (*Healthcare Effectiveness Data and Information Set*) is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. Empire's HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Record requests to Provider offices begin in mid January and Empire requests that the records be returned within 5 business days to allow time to abstract the records and request additional information from other Providers, if needed. Health plans use HEDIS data to encourage their contracted

providers to make improvements in the quality of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs.

For more information on HEDIS visit Empireblue.com

Select Providers, Select **Forms and Guides** (under the Provider Resources column). Scroll down and select Forms and Guides, then scroll down and select HEDIS in the Category drop down.

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

Overview of CAHPS®

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from Empire's Members about their experiences with Empire's Health Plans in the past year. This includes the Member's access to medical care and the quality of the services provided by Empire's network of Providers. Empire analyzes this feedback to identify issues causing Members dissatisfaction and works to develop effective interventions to address them. Empire takes this survey feedback very seriously.

Health Plans report survey results to National Committee for Quality Assurance ("NCQA"), which uses these survey results for the annual accreditation status determinations and to create National benchmarks for care and service. Health Plans also use CAHPS® survey data for internal quality improvement purposes.

Results of these surveys are shared with Providers annually via our provider newsletter, so they have an opportunity to learn how Empire Members feel about the services provided. Empire encourages Providers to assess their own practice to identify opportunities to improve patients' access to care and improve interpersonal skills to make the patient care experience a more positive one. Our Provider newsletters can be found online at empireblue.com/provider/news

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

Clinical Practice Guidelines

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

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines online. To access the guidelines, go to empireblue.com/provider Scroll to Review Policies

With respect to the issue of coverage, each Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving

treatment. The Certificate of Coverage and/or Schedule of Benefits supersedes the clinical practice guidelines.

Preventive Health Guidelines

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

The current guidelines are available on our website. To access the guidelines, go to empireblue.com/provider/Provider HomeHealth and Wellness Review Policies > [Preventive Health Guidelines](#).

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

Medical Record Standards

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

For more information on Medical Record standards, please go to [empireblue.com/provider/ Medical Record Review](http://empireblue.com/provider/Medical Record Review).

- Each Member will have a separate medical record
- Each medical record will verify that the PCP coordinates and manages care
- The retention period for medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later
- For Medicare Advantage members, the retention period for medical records shall be retained for a period of ten
- (10) years after the date of service,
- Prenatal Care – Physician will need to maintain a centralized medical record for the provision of prenatal care and all other related services

Additional Medical Record requirements are outlined in Quality Management Program.

Managed Care Reporting

The Healthcare Effectiveness Data and Information Set (HEDIS®) and Quality Assurance Reporting Requirements (QARR) measure performance on important aspects of preventive, acute and chronic healthcare issues. Empire collects and reports these measures annually.

Why Empire collects this data:

- Empire uses HEDIS/QARR results to measure its performance on important aspects of preventive, acute and chronic care.
- The performance measures in HEDIS are related to significant public health issues such as cancer, diabetes, smoking and heart disease.
- In addition to clinical measures, HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing.
- Empire annually compares its HEDIS/QARR rates to the regional and national benchmarks to evaluate its performance and identify opportunities for improvement of the quality of care its members receive and to address the needs of its members along the health continuum.

How you can help?

Physicians play an integral role in promoting the health of Empire's members. We realize the data collection process can be time-consuming, but your efforts assist us in assuring that all Empire members receive the appropriate preventive health interventions. To assist us in accurately capturing the data, please...

- document recommended services in a patient's medical record (i.e., mammogram screenings, cervical cancer screenings, colon cancer screenings, and immunizations). If the member has declined the recommendation, please include this information in your documentation as well. This will allow us to target our interventions more appropriately.
- document the outcomes of any specialist referrals.
- encourage members to provide you with the name of any specialists that they may have seen without a referral. This will help us ensure continuity and coordination of care and obtain additional information from the specialists.
- take time to review a medical record when it is requested by Empire for clinical information and please provide Empire with the requested information.
- submit claims in a timely manner.

Empire's HEDIS/QARR results are available on Empire's website at empireblue.com.

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

Records, Maintenance, Availability, Inspection and Audit

Medical Record Guidelines

Consistent and complete documentation in the medical record is an essential component of quality patient care. Medical records at primary care offices must be reflective of all services performed by the primary care practitioner (PCP), all ancillary and diagnostic tests ordered by a practitioner, and all services for which a member has been referred to another provider by a PCP (see coordination of care). The organization's medical record review is based on the best judgment of the reviewer against these

medical records standards. Any patterns or trends are also taken into consideration prior to arriving at the final score. In addition, the organization gives practices the opportunity to make sure that all documentation is provided to the organization before a final score is determined.

The following ratings are used to indicate the % of time the standards are documented in the medical record:

- Never = 0% of the time
- Occasionally = 25% of the time
- Generally = 50% of the time
- Frequently = 75% of the time
- Always = 100% of the time
- NA = Non-applicable

To help ensure that medical records are maintained in a manner which is current, detailed, legible and organized for the organization's members who are treated by a health care practitioner, the following Performance Standards are employed:

Performance Goal	The organization's documentation standards will be met in all medical records.
Access and Availability	Practitioner/practice sites shall maintain organized records in such a manner that permits timely and easy retrieval of patient information for each patient/practitioner encounter or, upon request, by other legitimate users.
Confidentiality	<p>Patient care offices or sites shall meet or exceed state and federal confidentiality requirements, including HIPAA and are expected to have implemented mechanisms that guard against unauthorized or inadvertent disclosure of confidential information. Records must be stored securely with only authorized personnel having access to the medical records. Patient care offices must ensure that the staff receives periodic training in confidentiality of member information.</p> <p>Medical records should be kept in a secure environment, away from public access, that allows access by authorized personnel only.</p> <p>Patient care offices or sites should be able to provide the organization, upon request, a written Policy and Procedure for the Release of Patient Information that demonstrates confidentiality of all patient information in accordance with applicable state and federal laws and evidence of continued training of office staff on confidentiality.</p>

Documentation Standards

The following standards will be met in the medical records at least 85% of the time:

Patient Identification	<ul style="list-style-type: none"> • Patient name or ID number (identification number) on all pages • Personal/biographical information (i.e., date of birth, patient address, employer, home/ work telephone number(s) and • Patient's ethnicity is documented on an intake form or with biographical information
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Overall Quality of Medical Records	<p>All medical record entries:</p> <ul style="list-style-type: none"> • Are signed or co-signed • Are dated • Are legible • History of current medical conditions are noted and dated • Past medical history noted, easily identifiable, and includes serious accidents, operations, and illnesses for members having at least three (3) visits. • Health maintenance is noted Problem list is updated as necessary • Medication list (includes both current and PRN medication) is updated as necessary BMI, nutrition, exercise, symptoms of depression, tobacco use, alcohol use, substance use, and sexual activity are noted for patients 14 years and older • Physical exams are documented • Clinical findings and evaluation for each visit is documented • Documentation of advance directive discussion in a prominent part of the medical record for adult patients who are Medicare Advantage members; and documentation on whether or not a patient has executed an advance directive with a copy to be included in the medical record. We encourage providers to maintain documentation of advance directive discussions and copies of executed advance directives in patients' files for other members.
Allergies/Adverse Reactions	<ul style="list-style-type: none"> • Medication allergies and adverse reactions are prominently noted and dated in the record. If no known allergies, NKA or NKDA is noted.
Continuity and Coordination of Care	<p>Labs/tests:</p> <ul style="list-style-type: none"> • Results of all ancillary services and diagnostic tests or studies ordered by a practitioner are reviewed by the PCP. They may be initialed or a note indicating the lab work was reviewed may be present in the progress/office note. • Indication that the patient has been notified of abnormal test or lab results and explicit follow-up plans for all abnormal labs or test results. <p>Consults:</p> <ul style="list-style-type: none"> • Consultant's reports or documentation of discussions with consulting physicians should be in the medical record. • The consultant's reports and/or specialty care providers summary has been reviewed by the provider. They may be initialed or a note indicating the summary was reviewed may be present in the progress/office note. • Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN. • There is a notation of any instructions/education given to patients regarding follow-up visits, care, treatment, or medication schedules, and diagnostic and therapeutic services where members are referred for services. • Home health nursing reports • Specialty physician reports • Hospital discharge reports • Outpatient/ambulatory surgery reports

Immunization Record	<ul style="list-style-type: none"> Childhood, adolescent and adult immunizations per the Organization's Preventive Health Guidelines
Lead Screening	<ul style="list-style-type: none"> Lead screening per state requirements and at the physicians discretion based on community or individual risks
Preventive Services	<ul style="list-style-type: none"> There is evidence of required age-specific preventive screenings based on approved practice guidelines and State Requirements.

Administrative Follow Up

Review Results	<p>Written results of the medical record review will be provided the day of the audit for on-site reviews. The practitioner/office must meet a performance goal of 85%.</p> <p>A written summary will be sent to all practitioners/offices within fifteen (15) business days of completion of the review for records mailed/faxed to the Plan. Any identified deficiencies will be noted in the letter in order for the office to implement improvement plans.</p>
Medical Record Improvement Plan	<p>For those offices that score 66%-84%, education will be provided on areas that require improvement in documentation. The Plan can make available medical record keeping tools and provide counseling on medical record standards or prevention monitoring. A medical record review will be conducted within six (6) to twelve (12) months.</p>
Follow-up to Medical Record Quality Improvement Plan	<p>Those practice sites that score 65% or below will be required to submit a Quality Improvement Plan (QIP) detailing how they will address the identified deficiencies. The QIP will be reviewed by the Plan, and a medical record review will be conducted again within six (6) to twelve (12) months.</p> <p>Those practices that, upon re-review, fail to take appropriate actions to improve their medical record keeping practices will be referred to the organization's Medical Director.</p> <p>For additional information on the Medical Record Standards, please refer to Quality Management.</p>

Medical Record Review

Your compliance with these standards is assessed through medical record audits. These audits are conducted annually by nurses from our Quality Department and individual scores are communicated to the physician. Empire has set a minimum compliance threshold of 85 percent for these standards. All physicians are expected to achieve or surpass this threshold score. Any physician scoring below this threshold will be reviewed again within a year. If the physician scores below this threshold on two consecutive reviews he/she will be referred to Empire's Credentialing Committee for evaluation. Possible actions by the Credentialing Committee may include educational efforts, focused reviews, and in some cases, termination from Empire's physician network.

- The review of medical records may also be done for one or more of the following, when applicable: Follow-up on prior review findings or corrective action plan
- HEDIS/QARR quality improvement studies

- Investigation of quality of care complaints
- Sentinel Event review

All physicians are required to participate in Empire's Quality and Medical Management Programs to meet New York State Department of Health, federal and regulatory requirements. Physicians are obligated by contract to allow inspection, auditing, and duplication of medical records during quality improvement, medical management, and peer or grievance reviews. Empire, or a designated representative, will request submission of medical records in connection with such reviews. PCPs are also required to assist in the orderly transfer of medical records when a patient changes his or her primary care physician.

If you have any question regarding the medical record documentation standards or the quality improvement process in general, contact Empire Physician Services at 1-800-552-6630, 8:30 a.m. to 5:00 p.m. EST, Monday to Friday.

Multicultural Health

Multicultural Health Overview

Empire identifies and addresses health and healthcare disparities among Members based on key clinical quality metrics, evidence-based research, and member experience metrics. We aim to help eliminate these disparities and promote health equity. Our core strategies for helping to mitigate disparities and achieve equity include the following:

1. Monitor the quality of health care to identify actionable health and health care disparities trends
 - a. Identify clinical and geographic areas exhibiting health and health care disparities and design appropriate interventions to help close those gaps
 - b. Establish baseline data and measures/evaluates the results of program interventions
 - c. Support Member access to equitable treatment, standards of care and services based on their Plan benefits
2. Promote Culturally and Linguistically Appropriate Services ("CLAS")
 - a. Offer education, tools and subject matter expertise to Providers and Facilities that may help them achieve the shared goal of providing quality care and service equally to their patients
 - b. Facilitate cultural competency of Empire associates to help meet the Members' needs for access to culturally sensitive, linguistically appropriate care and service
 - c. Offer education, tools and subject matter expertise to Members that may help them improve their health literacy, allowing better communication with their doctors and Empire about their health care and service
 - d. Promote the Department of Health and Human Services Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS standards).
<https://www.thinkculturalhealth.hhs.gov/clas/standards>
3. Develop programs to help improve health status and outcomes
 - a. Promote consumer-centered care that addresses the Members' values, needs and preferences in reaching optimal health care and outcomes standards

- b. Support communities in which Empire does business with cultural and linguistic programs and services
- c. Collaborate with other industry and government efforts to help reduce and eliminate health disparities

Empire Innovation

[MyDiversePatients.com](#): An online resource to support your diverse patient panel

Empire strives to meet the needs of our diverse membership and promotes access to consistently high quality standards across our networks. We believe that by offering our Providers and Facilities the types of learning experiences described above, we can help keep all our Members healthy. In addition, these online experiences reinforce our commitment to promoting health equity for our diverse Members as referenced in our Provider and Facility contractual non-discrimination provisions.

All learning experiences can be found on [MyDiversePatients.com](#), a website that features robust resources for Providers to help support addressing racial and ethnic disparities in health and health care:

- CME learning experiences about disparities, potential contributing factors, and opportunities for Providers to enhance care.
- Real-life stories about diverse patients and the unique challenges they face.
- Tips and techniques for working with your diverse patients to promote improvement in health outcomes.

While there's no single easy answer to the issue of health care disparities, the vision of [MyDiversePatients.com](#) is to start reversing these trends...one patient at a time.

Embrace the knowledge, skills, ideals, strategies, and techniques to accelerate your journey to becoming your patients' trusted health care partner by visiting [MyDiversePatients.com](#) today. Descriptions of the learning experiences and tools are listed below.

Moving Toward Equity in Asthma Care

Built upon extensive research and data analytics, the "Moving Toward Equity in Asthma Care" online CME experience offers 1 hour of Continuing Medical Education ("CME") credit through the American Academy of Family Physicians, and includes scenarios that fulfill the following learning objectives:

- Describe common racial and ethnic asthma disparities – and their effects on diverse patients' ability to successfully control their asthma.
- Describe ways Providers may unknowingly contribute to poor asthma care for diverse populations.
- Explain ways Providers can improve the quality of asthma care to enhance outcomes among African Americans, Hispanic and Asian patients.
- Explain the importance of using spirometry to assess the severity of asthma accurately.
- Explain the concept of "unconscious bias."

A "Resources" section contains additional information on asthma disparities.

The experience was developed in an effort to address the substantial gaps in asthma care and outcomes for diverse populations and can be accessed at www.mydiversepatients.com/le-asthma.html.

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

Asthma & Me App

Are you looking for innovative ways to educate and engage your patients with asthma? The Asthma & Me app is an interactive and fun way to show patients the physiology of their asthma. The app is a free support tool that uses face detection technology along with augmented reality to simulate a diseased airway.

- When the camera on the mobile device is aimed at the patient's face, an animation of the lungs is overlaid and a short video illustrating the physiology of an asthma attack is produced and recorded.
- The video can be used to facilitate discussion with the patient about what occurs during an asthma attack – airway inflammation, bronchiole constriction, and mucus production.
- The video can be saved and shared via social media or email.
- The app is currently available in three languages: English, Spanish, and Tagalog. The language is selected based on the patient's smartphone or tablet settings.

The Asthma & Me app can be accessed at MyDiversePatients.com using your smartphone, tablet, or computer. The app supplements the “**Moving Toward Equity in Asthma Care**” online provider CME experience, which is also available on the site as well as www.mydiversepatients.com/le-asthma.html

Creating an LGBT-Friendly Practice

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

Visit www.mydiversepatients.com/le-lgbt.html for free 24/7 access to the experience – either via computer, tablet or smartphone. The course has been approved for 1 AAFP Prescribed credit, which is equivalent to AMA PRA Category 1 Credit™.

Reducing Health Care Stereotype Threat (“HCST”): Assuring your diverse patients they are not being judged due to their race/ethnicity

Your diverse patients may feel threatened about being personally reduced to group stereotypes. Their fear of being prejudged or stigmatized based on phenotype may be omnipresent throughout their life

journeys and may be present during health care interactions with you or your team. A perceived health care stereotype threat is not the same as discrimination. Instead, it is a situational, psychosocial phenomenon that may contribute to disparities.

As a trusted health care Provider, you can make a difference. Find out how to recognize when your patients may be experiencing this threat. Then explore how to foster a threat-safe environment with practical shifts you can make today.

Visit the Provider pages online at www.mydiversepatients.com/le-hcst.html for free 24/7 access to the experience—either via your computer, tablet or smartphone. You will better understand Health Care Stereotype Threat (HCST) and its implications for multicultural patient groups and also learn how to recognize when your patients may be experiencing HCST. In addition, you will learn the benefits of reducing HCST to both your patients and your practice. The course is approved for 1 AAFP Prescribed credit, which is the equivalent to AMA PRA Category 1 Credit™.

Medication Adherence

You want what's best for your patients' health. So, it's challenging when a patient doesn't follow your prescribed treatment plan. Why do approximately 50% of patients with chronic illness stop taking their medications within one year of being prescribed¹? Where's the disconnect? What can be done differently?

As a health care provider, you care about your patients. However, you may only be seeing and hearing the tip of the iceberg—the observable portion of the thoughts and emotions your patient is experiencing. The barriers that exist under the waterline -- the Titanic-sized, often invisible, patient self-talk that may not get discussed -- can create a misalignment between patient and provider.

So we've created an online learning experience for the skills and techniques that may help you navigate these uncharted patient waters. After completing the learning experience you'll know how to see the barriers, use each appointment as an opportunity to build trust, and bring to light the concerns that may be occurring beneath the surface of your patient interactions. Understanding and addressing these concerns may help improve medication adherence—and you'll earn CME credit along the way. The course is approved for 1 AAFP Prescribed credit, which is the equivalent to AMA PRA Category 1 Credit™.

Take the next step. Go to MyDiversePatients.com > *The Medication Adherence Iceberg: How to navigate what you can't see* to enhance your skills.

¹ Center for Disease Control and Prevention. (2017, February 1). *Overcoming Barriers to Medication Adherence for Chronic Conditions*. Retrieved from <https://www.cdc.gov/cdcgrandrounds/archives/2017/february2017.htm>

Centers of Medical Excellence

Empire currently offers access to Centers of Medical Excellence ("CME") programs in solid organ and blood/marrow transplants, bariatric surgery, cancer care, cardiac care, maternity, spine surgery, and knee/hip replacement surgery. As much of the demand for CME programs has come from National

Accounts, most of our programs are developed in partnership with the Blue Cross and Blue Shield Association (“BCBSA”) and other Blue plans to ensure adequate geographic coverage. The BCBSA refers to its designated CME providers as Blue Distinction Centers for Specialty Care™ (“BDC”). Using objective information and input from the medical community, the BCBSA has designated hospitals as Blue Distinction Centers that are proven to outperform their peers in the areas that matter to you – quality, safety and, in the case of Blue Distinction Centers+ (“BDC+”), cost efficiency.

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

For both the BDC and Empire CME programs, selection criteria are designed to evaluate overall quality, providing a comprehensive view of how the Facility delivers specialty care. More information on the programs can be accessed online at empireblue.com. To view the BDC and Empire CME program information [Click Here](#)

Transplant

- Blue Distinction Centers for Transplant™ (“BDCT”) launched in 2006.
- More than 115,082 people in the United States were waiting for a lifesaving organ transplant from one of the nation’s more than 140 transplant centers in 2017. There were nearly 34,800 organ transplants in 2017. This was the fifth consecutive record-breaking year.
- Blue Distinction Centers and Blue Distinction Centers+ for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each Facility meets stringent clinical criteria, established in collaboration with expert physicians’ and medical organizations’ recommendations**, including the Center for International Blood and Marrow Transplant Research (“CIBMTR”), the Scientific Registry of Transplant Recipients (“SRTR”), and the Foundation for the Accreditation of Cellular Therapy (“FACT”), and is subject to periodic re-evaluation as criteria continue to evolve. Both Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.
- Hospitals receiving the Blue Distinction Center+ for Transplants designation have met the Blue Distinction Centers’ standards for quality while also demonstrating better cost-efficiency relative to their peers.
- The Empire CME Transplant Network is a wrap-around network to the BDCT program and offers Members access to an additional 60 transplant facilities. When BDCT and Empire CME are combined, Members have access to 200 transplant specific programs for heart, lung, combined heart/lung, liver, liver/kidney, pancreas, kidney, combined kidney/pancreas, and bone marrow/stem cell transplant.

Cardiac Care

- Blue Distinction Centers for Cardiac Care® launched in January 2006.

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

Bariatric Surgery

- Blue Distinction Centers for Bariatric Surgery® launched in 2008
- According to the National Center for Health Statistics report released in November 2015: Prevalence of Obesity among Adults and Youth has grown to more than one-third (36.5%) of U.S. adults which have been diagnosed with obesity, and 32.3% for young adults aged 20-39. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death.
- Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery (“ASMB”) and the American College of Surgeons (“ACS”), and is subject to periodic re-evaluation as criteria continue to evolve
- The 2017 Blue Distinction Centers for Bariatric Surgery program uses updated Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (“MBSAQIP”) accreditation levels, which focus on site of service. With this design change, each facility can apply to achieve the BDC or BDC+ designation, as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center (“ASC”).

Cancer Care

- Blue Distinction Centers for Cancer Care is a new national designation program that recognizes physicians, physician practices, cancer centers, and hospitals for their efforts in coordinating all types of cancer care. This program incorporates patient-centered and data-driven practices, to coordinate care better and to improve quality of care and safety, as well as affordability. Providers in this Program are paid under a provider agreement with their local BCBS Plan that has value-based reimbursement, rather than traditional fee-for-service, so they must perform against both quality and cost outcome targets in order to receive incentives and rewards for better health outcomes.
- Designations will be awarded on an ongoing basis, and the program will continue to expand in the future.

Spine Surgery

- Blue Distinction Centers for Spine Surgery® launched in November 2009.
- Studies confirm that as many as eight out of 10 Americans suffer from some sort of back pain. Many ways to treat back pain are available, and your doctor can guide you toward the most

appropriate recommendation for your situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option.

- Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than non-designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.
- Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.
- To date, we have designated hospitals in the majority of states across the U.S.

Knee and Hip Replacement

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

Maternity Care

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

Substance Use Treatment and Recovery

- Blue Distinction Centers for Substance Use Treatment and Recovery launched in January of 2020 to address the treatment of substance use disorders, including opioid use disorder.
- The program aims to improve patient outcomes and cost by addressing the fragmented delivery of substance use disorder treatment. Designations are awarded based on quality criteria that support delivery of timely, coordinated, multidisciplinary, evidence-based care, with a focus on quality improvement and patient-centered care

Ventricular Assist Devices

- Empire’s Center of Medical Excellence Ventricular Assist Device (VAD), small implantable pumps that assist the heart by pumping blood in the circulatory system of individuals with end-stage heart failure, launched in 2017.
- According to the Centers for Disease Control and Prevention Heart failure reports that about 5.7 million adults in the United States have heart failures a major public health problem associated with significant hospital admission rates, mortality, and costly health care services.
- Based on registry data, >15,000 left ventricular assist devices (LVADs) were implanted from June 2006 to December 2014. An estimated 3000+ VADs will be implanted worldwide this year, but the volume is expected to increase as newer, smaller devices receive regulatory approval,

clinical indications slowly expand and the continued increase in centers certified to place these devices.

Chimeric Antigen Receptor Therapy (“CAR-T”)

- The FDA has approved a new product Chimeric Antigen Receptor T-cell (CAR-T), a CD19-directed genetically modified autologous T cell immunotherapy which brings new treatment options for cancer patients.
- Two (2) Chimeric Antigen Receptor T cell therapies (CAR-T) have been recently approved by the FDA to treat certain patients with leukemia and lymphoma:
 1. Yescarta for treatment in Adult Patients
 2. Kymriah for treatment in Pediatric and Adult Patients
- These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting and Care and follow-up continues over the first year.
- These Members are managed by the transplant Case Managers and Empire Medical Policy requires the procedure be performed at a Certified CAR-T center.
- Currently there is not a designation or contract for CAR-T therapy and each case requires a Letter of Agreement. In 2020 Empire Centers of Medical Excellence will have a designation and contract for CAR-T
- The Blue Cross Blue Shield Association has a designation, but not a contract requirement for CAR-T Providers.

Network Participation Termination and Appeals

Purpose and Goal

The Network Practitioner Termination and Appeals Policy and Procedure is designed to define the criteria by which Empire evaluates certain managed healthcare practitioners participating in our network for possible termination or other actions, as necessary.

Policy Statement

Empire contracts with various practitioners so that it can offer quality, accessible, cost-efficient healthcare to its managed care network members. Empire monitors the care provided by the practitioners participating in our network and re-credentials them every three years to ensure that such healthcare is being rendered.

Participation Termination and Appeals

Certain circumstances, including but not limited to, professional misconduct of a participating practitioner within our managed care network may require Empire to take certain actions with respect to the practitioner’s participation in the network. Actions may include termination of the practitioner’s network participation privileges, as set forth below.

Voluntary Terminations

- All providers who wish to terminate their contractual relationship with Empire must abide by the terms of the provider agreement, including but not limited provisions concerning notice and continuation of care (See Continuity of Care)

Non-Renewals

- Empire may elect to non-renew a provider’s agreement and will provide notice of non-

renewal in accordance with the terms of the provider agreement. Please note that non-renewal is not considered a termination under New York Public Health Law 4406-d.

Immediate Terminations

- Immediate Terminations can occur in the following instances:
 - Sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or Federal Employee Health Benefit Plan.
 - A determination that the conduct of a participating practitioner in our managed care network poses the threat of imminent harm to the health of network members; or
 - A finding that a participating practitioner in our managed care network has perpetrated an act of fraud; or
 - A final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a participating practitioner in our managed care network to practice.
- In the above cases, the participating practitioner in our managed care network will be immediately terminated from all managed care networks and will not be eligible for hearing.

Administrative Terminations

- These can occur when an administrative issue arises with respect to a participating practitioner in our managed care network and may include, but is not limited to, noncompliance with Empire's policies and procedures, such as Empire's Advance Patient Notice policy (APN). Please see below for hearing procedures.

Hearings:

- If Empire proposes to terminate a health care professional's agreement and that health care professional is entitled to a hearing under New York law, the following process shall apply:
- The termination notice shall include:
 - The reason(s) for the proposed termination and
 - Notice that the health care professional has the right to request a hearing or review, at the health care professional's discretion, before a panel appointed by Empire;
 - A statement that the health care professional has 30 days to request a hearing; and
 - A statement that Empire will schedule a hearing date within thirty days after the date of its receipt of a request for a hearing.

A health care professional's failure to submit a request for a hearing within 30 days will be deemed a waiver of any hearing rights. The proposed contract termination will become final and you will not be afforded any additional appeal rights.

The hearing panel will be comprised of a minimum of three persons, of whom at least one-third will be a clinical peer in the same discipline and the same or similar specialty as the health care professional. The panel can consist of more than three persons, provided the number of clinical peers constitutes one-third or more of the total membership. The hearing panel will render a decision in a timely manner. Decisions will include one of the following and will be provided in

writing to the provider: reinstatement; provisional reinstatement with conditions set forth by Empire, or termination. Decisions of termination shall be effective not less than 30 days after the receipt by the health care professional of the hearing panel's decision. In no event shall determination be effective earlier than 60 days from receipt of the notice of termination.

Limitation on Terminations

- A practitioner's network participation privileges will not be terminated due to any of the following reasons:
 - Advocating on behalf of a member
 - Filing a complaint against Empire
 - Appealing a decision by Empire
 - Providing information or filing a report that Empire engaged in conduct prohibited pursuant to Section 4406-c of the Public Health Law Requesting a hearing or review

Appeals Process

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

Reporting Requirements

When Empire takes a Professional Review Action with respect to a professional provider's participation in one or more Empire networks, Empire may have an obligation to report such to the NPDB and/or HIPDB. Once Empire receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current National Practitioner Data Bank (NPDB) Guidebook and the Healthcare Integrity and Protection Data Bank (HIPDB) Guidebook, the process set forth in the NPDB Guidebook and the HIPDB Guidebook will govern.

Medicare Advantage Provider Website

Please refer to the Medicare Eligible website online for additional information at www.empireblue.com/medicareprovider.

Medicare Advantage Provider Manuals are available on <https://www.Empireblue.com>. Select Provider then choose Policies, Guidelines and Manuals under the horizontal menu, scroll to the Provider Manual section and select Download the Manual. Scroll to the Provider Manual Library section and choose Medicare Advantage Provider Manual

- [Medicare Advantage Provider Guidebook](#)

Federal Employee Health Benefits Program (FEHBP)

BlueCross BlueShield Federal Employee Program		Government-Wide Service Benefit Plan	Basic
Member Name I M SAMPLE	www.fepblue.org		
Member ID R30048615			
Enrollment Code 112	RxGrp 65006500		
Effective Date 01/01/2002	RxBIN 610415		
	RxPCN PCS		

BlueCross BlueShield Federal Employee Program		Government-Wide Service Benefit Plan	PPO
Member Name I M Sample	http://www.fepblue.org		
Member ID R30047600			
Enrollment Code 104			
Effective Date 01/01/2006			
RX Bin No. 610415			
RX Group No. 65006500			

FEHBP Requirements

Providers and Facilities acknowledge and understand that Empire participates in the Federal Employees Health Benefits Program ("FEHBP"). The Empire FEHBP encompasses the Blue Cross Blue Shield Association Service Benefit Plan, otherwise known as "Federal Employee Program®" or "FEP®", – the health insurance Plan for federal employees. Providers and Facilities further understand and acknowledge that the FEHBP is a federal government program and the requirements of the program are subject to change at the sole direction and discretion of the United States Office of Personnel Management. Providers and Facilities agree to abide by the rules, regulations, and other requirements of the FEHBP as they exist and as they may be amended or changed from time to time, with or without prior notice. Providers and Facilities further agree that, in the event of a conflict between the Provider or Facility agreement or this Provider Manual and the rules, regulations, or other requirements of the FEHBP, the terms of the rules, regulations, and other requirements of the FEHBP shall control. When a conflict arises between federal and state laws and regulations, the federal laws and regulations supersede and preempt the state or local law (Public Law 105-266). In those instances, FEHBP is exempt from implementing the requirements of state legislation.

Submission of Claims under the Federal Employees Health Benefits Program

All Claims under the FEHBP must be submitted to Plan for payment within the timeframe listed in the

Provider or Facility Agreement. This timeframe applies from the date of discharge or from the date of the primary payer's explanation of benefits. Providers and Facilities agree to provide to Plan, at no cost to Empire or Member, all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. If Plan is the secondary payer, the timeframe will not begin to run until Provider or Facility receives notification of primary payer's responsibility. Plan is not obligated to pay Claims received after the timeframe indicated in the Agreement. Except where the Member did not provide Plan identification, Provider and Facility shall not bill, collect, or attempt to collect from Member for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.

Erroneous or duplicate Claim payments under the FEHBP

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

Coordination of Benefits for FEHBP

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

FEHBP Waiver requirements

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

FEHBP Member Reconsiderations and Appeals

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

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

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

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

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

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

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

FEHBP Formal Provider and Facility Appeals

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

A formal Provider or Facility appeal is a written request from the rendering Provider or Facility, to his/her local Plan, to have the local Plan re-evaluate its contractual benefit determination of their post-service Claim; or to reconsider an adverse benefit determination of a pre-service request. The request must be from a Provider or Facility and must be submitted in writing within 180 days of the denial or benefit limitation. In most cases, this will be the date appearing on the Explanation of Benefits/Remittance sent by the Plan. For pre-service request denials, the date will be the date appearing on the Plan’s notification letter.

The request for review may involve the Provider or Facility’s disagreement with the local Plan’s decision about any of the **clinical issues** listed below where the Providers or Facilities are *not* held harmless. Local Plans should note that this list is not all-inclusive.

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

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

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

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

FEHBP Inpatient Skilled Nursing Facility Care

- Effective January 1, 2018 benefits are available for up to 30 days of inpatient skilled nursing facility (“SNF”) care per benefit year for Standard Option Members who are not enrolled in Medicare Part A.
- Hospitals and Plan staff must be proactive in identifying Members for whom a SNF stay is an appropriate level of care in the continuum toward transition home.
- The Member must be enrolled in case management (“CM”) and the signed consent for CM must be received by the case manager prior to precertification approval of the SNF admission. This will require that the hospital discharge planning staff collaborate with the Plan case manager, and in some cases, will necessitate the hospital case manager/discharge planner’s assistance in delivering the consent to the Member and having it returned to the Plan after the Member/proxy signs the document.
- The transferring facility must submit a detailed description of the Member’s clinical status and the proposed treatment plan for the Plan’s review of the proposed admission.
- Once the Member is admitted and subsequently within the timeframes established by the Plan, the SNF representative must provide specific information regarding the Member’s status, progress towards goals, changes to the treatment plan and/or discharge plan (if applicable) and documentation of any obstacles preventing the Member from achieving the goals.
- The attending physician in the SNF must write admission orders and review the preliminary treatment plan within 24 hours of the Member’s admission. Members admitting on a ventilator must be seen by a pulmonologist within 12 hours of admission and respiratory therapy be available in the facility 24 hours/day.
- Members admitted for rehabilitation must receive an evaluation by a physical therapist and a physical therapy treatment plan must be in place within 16 hours of admission. Members admitted primarily for rehabilitation must receive at least 2 hours of physical therapy and occupational therapy combined at least 5 days per week (logs must be provided to the Plan to document therapy time).

BlueCard

BlueCard Program Overview

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

For more information about the BlueCard Program, Providers and Facilities can access the BlueCard Provider Manual, online at empireblue.com/provider/ >Review Policies> [Provider Manuals](#)

BlueCard ID card Sample:

	BlueCross BlueShield of Geography	Blue Product	ALPHA Employer Group
Member Name Member Name Member ID XYZ123456789		Dependents Dependent One Dependent Two Dependent Three	
Group No.	023457	Plan	PPO
BIN	987654	Office Visit	\$15
Benefit Plan	HIOPT	Specialist Copay	\$15
Effective Date	00/00/00	Emergency	\$75
Plan Code	123	Deductible	\$50
			

	BlueCross BlueShield of Geography	www.BluePlan.com
Members: See your benefit booklet for covered services. Possession of this card does not guarantee eligibility for benefits.		Customer Service: 1-800-234-5678
Hospitals or physicians: file claims with your local BlueCross and/or BlueShield Plan.		Outside of Area: 1-800-810-2583
BlueCross and BlueShield of Geography provides administrative services and does not assume any financial risk or claims.		Eligibility: 1-800-676-2583
		Pharmacy Benefits: 1-800-888-1234
		Gamma Vision*: 1-800-987-6543
		* Not a BlueCross and BlueShield product
BETA Pharmacy Management		BlueCross and BlueShield of Geography P.O. Box 01234 City, State 01234-1234 An independent licensee of the BlueCross and BlueShield Association.
		Pharmacy benefits administrator

BlueCard (Out of Area) Members:

		Blue Product ALPHA Employer Group	
Member Name Member Name Member ID XYZ123456789		Dependents Dependent One Dependent Two Dependent Three	
Group No.	023457	Plan	PPO
BIN	987654	Office Visit	\$15
Benefit Plan	HIOPT	Specialist Copay	\$15
Effective Date	00/00/00	Emergency	\$75
Plan Code	123	Deductible	\$50
			

		www.BluePlan.com	
Members: See your benefit booklet for covered services. Possession of this card does not guarantee eligibility for benefits.		Customer Service: 1-800-234-5678 Outside of Area: 1-800-810-2583 Eligibility: 1-800-676-2583 Pharmacy Benefits: 1-800-888-1234 Gamma Vision*: 1-800-987-6543 * Not a BlueCross and BlueShield product	
Hospitals or physicians: file claims with your local BlueCross and/or BlueShield Plan.		BlueCross and BlueShield of Geography P.O. Box 01234 City, State 01234-1234 An independent licensee of the BlueCross and BlueShield Association.	
BlueCross and BlueShield of Geography provides administrative services and does not assume any financial risk or claims.			
BETA Pharmacy Management		Pharmacy benefits administrator	

Health Insurance Marketplace (Exchanges)

Health Insurance Marketplace

The Affordable Care Act (ACA) authorized the creation of Health Insurance Marketplaces (commonly referred to as exchanges) to help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans.

Empire offers qualified health plans on the Individual or Small Business Health Options Program (SHOP) Exchange in many states, as well as health plans not purchased on public exchanges. Qualified health plans on the Individual and SHOP Exchange follow the same policies and protocols within this Provider Manual, unless otherwise stated in the Provider or Facility Agreement.

Updates about Empire's ACA compliant health plans and the networks supporting these plans are published in Empire's provider newsletter, and sent via Empire's email service. To sign up for Provider Communications for, go to <https://messageinsite.com/networkupdate>.

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

Important reminder:

Providers and Facilities are able to confirm their participation status in our different networks by using the Find a Doctor tool. Please see the **Online Provider Directories and Demographic Data Integrity** section for more details.

Audit and Review

Empire's Audit Policy

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

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

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

In order to conduct such reviews and audits, Empire or its designee may request documentation, most commonly in the form of patient medical records and/or itemized bill. Empire may accept additional documentation from Provider or Facility that typically might not be included in medical records such as other documents substantiating the treatment or health service or delivery of supplies.

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

Definition:

The following definitions shall apply to this Audit section only:

- Agreement means the written contract between Empire and Provider or Facility that describes the duties and obligations of Empire and the Provider or Facility, and which contains the terms and conditions upon which Empire will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Member(s).
- Appeal means Empire's or its designee's review of the disputed portions of the Audit Findings, conducted at the written request of a Provider or Facility and pursuant to this Policy.
- Appeal Response means Empire's or its designee's written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.

- Audit means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining appropriate reimbursement under the terms of the Agreement.
- Notice of Overpayment means a document that constitutes notice to the Provider or Facility that Empire or its designee believes an overpayment has been made by Empire. The Notice of Overpayment shall contain administrative data relating to the amount of overpayment. Unless otherwise stated in the Agreement between the Provider or Facility and Empire, Notice of Overpayment shall be sent to Provider or Facility.
- Business Associate or designee means a third party designated by Empire to perform an Audit or any related function on behalf of Empire.
- Provider or Facility means an entity with which Empire has a written Agreement.
- Provider Manual means the proprietary Empire document available to the Provider and Facility, which outlines Reimbursement Requirements and Policies
- Recoupment means the recovery of an amount paid to Provider or Facility which Empire has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and Empire. A Recoupment is generally performed against a separate payment Empire makes to the Provider or Facility which is unrelated to the services which were the subject of the overpayment, unless an Agreement expressly states otherwise or is prohibited by law. Recoupments shall be conducted in accordance with applicable laws and regulations.
- Supporting Documentation means the written material contained in a Member's medical records or other Provider or Facility documentation that supports the Provider's or Facility's claim.

Policy

Upon request from Empire or its designee, Providers and Facilities are required to submit additional documentation for claims identified for pre-payment review or post payment audit.

Empire or its designee will use the following guidelines for records requests for claims identified for prepayment review or post payment audit:

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

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

Procedure:

1. Review of Documents. Empire or its designee will request in writing any supporting documentation required for audit or review. The Provider or Facility will supply the requested documentation within the time frame outlined above.
2. Scheduling of Audit (Hospital Bill Audits Only). After review of the documents submitted, if Empire or its designee determines an Audit or Review is required, Empire or its designee will call the Provider or Facility to request a mutually satisfactory time for Empire or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.
3. **Rescheduling of Audit**. Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Empire or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's or Facility's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Empire or its designee due to Provider's or Facility's rescheduling. . While Empire or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Empire or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Empire or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.
4. Under-billed and Late-billed Claims. During an on-site audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by Empire during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit. These Claims may, however, be submitted (or resubmitted with provider adjustment form for under-billed Claims) to Empire for adjudication.
5. On-Site and Desk Audits.
 - a. On-site Audits Empire or its designee may conduct Audits on-site at the Provider's or Facility's location. If Empire or its designee conducts an Audit at a Provider's or Facility's location, Provider or Facility will make available suitable work space for Empire's or its designee's on-site Audit activities. During the Audit, Anthem or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Member authorization. When conducting credit balance reviews, Provider or Facility will give Empire or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Empire or its designee will have access to Provider's or Facility's patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Empire or its designee access to the items requested to complete the Audit, Empire or its designee may opt to complete the Audit based on the information available. All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.
 - b. Desk Audits Empire or its designee may conduct Audits from its offices. Facility or Provider will comply with timeline and specific requested documentation listed in Empire's request for additional documentation.
6. **Completion of Audit (On-site audit only)** . Upon completion of the Audit, Empire or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is

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

7. **Provider or Facility Appeals.** See Audit Appeal Policy.
8. **No Appeal(On-site audit only).** If the Provider or Facility does not formally Appeal the findings in the final Audit Report and submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and Empire or its designee will process adjustments to recover the amount identified in the final Audit Report.

Documents Reviewed During an Audit:

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

- A. Confirm that Health Services were delivered by the Provider or Facility follow the treatment plan.

Auditors will verify that Provider's or Facility's treatment plan reflected the Health Services delivered by the Provider or Facility. The services are generally documented in the Member's health or medical records. The Provider or Facility must review, approve and document all such policies and procedures by any applicable accreditation bodies. Policies shall be made available for review by the auditor.

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

Auditors may also review the Member's health record documents. The health record includes the clinical data on diagnoses, treatments, and outcomes. A health record generally includes pertinent information related to care and must support services billed by the Provider or Facility.

Audit Appeal Policy

Purpose:

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

Procedure:

1. Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the findings in the Notice of Overpayment. An Appeal of the Notice of Overpayment must be in writing and received by Empire or its designee within thirty (30) calendar days of the date of the

Notice of Overpayment unless State Statute expressly indicates otherwise. The Appeal should address the findings from the Notice of Overpayment that Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. Retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or State Statute.

2. Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Empire or its designee shall issue an Appeal Response to the Provider or Facility. Empire's or its designee's response shall address each matter contained in the Provider's or Facility's Appeal. If appropriate, Empire's or its designee's Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Notice of Overpayment. Empire's or its designee's response shall be sent via email, mail or portal to the Provider or Facility within thirty (30) calendar days of the date Empire or its designee received the Provider's or Facility's Appeal and Supporting Documentation.
3. The Provider or Facility shall have fifteen (15) calendar days from the date of Empire's or its designee's Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to Empire or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, Empire or its designee shall begin recoupment of the amount contained in Empire's or its designee's response, and a confirming recoupment notification will be sent to the Provider or Facility.
4. Upon receipt of a timely Provider or Facility appeal response, complete with Supporting Documentation as required under this Policy, Empire or its designee shall formulate a final Appeal Response. Empire's or its designee's final Appeal Response shall address each matter contained in the Provider's or Facility's response. Empire's or its designee's final Appeal Response shall be sent via email, mail or portal to the Provider or Facility within fifteen (15) calendar days of the date Empire or its designee received the Provider or Facility response and Supporting Documentation.
5. If applicable in the state, the Provider or Facility shall have fifteen (15) calendar days from the date of Empire's or its designee's final Appeal Response to send a remittance check to Empire or its designee. If no remittance check is received within the fifteen (15) calendar day timeframe, Empire or its designee shall recoup the amount contained in Empire's or its designee's final Appeal Response.

Fraud, Waste and Abuse Detection

We are committed to protecting the integrity of our health care programs and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse (FWA). Combating FWA begins with knowledge and awareness.

- *Fraud – intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit. This includes, knowingly soliciting, receiving, and/or offering compensation to encourage or reward referrals for items or services and/or making prohibited referrals for certain designated health services.*
- *Waste – includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.*
- *Abuse – when health care providers or suppliers do not follow appropriate medical billing/documentation practices or medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.*

Investigation Process

The Special Investigations Unit (“SIU”) investigates suspected incidents of FWA for all types of services. We may take corrective action with a Provider or Facility, which may include, but is not limited to:

- *Written warning and/or education:* We send letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or requests for repayment, or may advise of further action.
- *Medical record review:* We review medical records to investigate allegations or validate the appropriateness of Claims submissions.
- *Edits:* A certified professional coder or investigator evaluates Claims and places payment or system edits in Empire’s Claims processing system. This type of review prevents automatic Claims payments in specific situations.
- *Recoveries:* We recover overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from our network, or legal action.

Prepayment Review

One method Empire uses to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to Empire’s attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider or Facility is an outlier compared to his/her/its peers.

Once a Claim, or a Provider or Facility, is identified as an outlier or has otherwise come to Empire’s attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination that the Provider’s or Facility’s actions may involve FWA, the Provider or Facility is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider or Facility is placed on prepayment review the Provider or Facility will receive written notice of being placed on prepayment review. This means that the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Empire can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Empire in accordance with this requirement will result in a denial of the Claim under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, Empire may review coding, documentation, and other billing issues. In addition, we may use one or more clinical utilization management guidelines in the review of Claims submitted by the Provider or Facility, even if those guidelines are not used for all Providers or Facilities delivering services to Plan Members.

The Provider or Facility will remain subject to the prepayment review process until Empire is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our network.

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

Acting on Investigative Findings

In addition to the previously mentioned actions, we may refer suspected criminal activity committed by a Member, Provider or Facility to the appropriate regulatory and/or law enforcement agencies

Recoupment/Offset/Adjustment for Overpayments

Empire shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Empire to Provider or Facility (“Overpayment Amount”) against any payments due and payable by Empire or any Affiliate to Provider or Facility with respect to any Health Benefit Plan under this Agreement or under any provider agreement between Provider and an Affiliate regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Empire that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount to Empire within thirty (30) calendar days of the date of the overpayment refund notice from Empire to the Provider or Facility. If the Overpayment Amount is not received by Empire within the thirty (30) calendar days following the date of such notice letter, Empire shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Empire or an Affiliate to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider or Facility agrees that all future Claim payments, including Affiliate Claim payments, applied to satisfy Provider’s or Facility’s repayment obligation shall be deemed to have been legally paid to Provider or Facility in full for all purposes, including Affiliates and/or Regulatory Requirements as defined by the Provider or Facility Agreement. Should Provider or Facility disagree with any determination by Empire or a Plan that Provider or Facility has received an overpayment or improper payment, Provider or Facility shall have the right to appeal such determination under Empire’s procedures set forth in the Provider Manual, provided that such appeal shall not suspend Empire’s right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Empire reserves the right to employ a third party collection agency in the event of non-payment.

Pharmacy Home Program

The availability and access to opioid medications used for the treatment of acute and chronic health conditions is at an all-time high. This access to healthcare is helping patients live longer and healthier lives. However, it can also lead to safety concerns when Members are on multiple controlled medications that are prescribed by multiple healthcare providers. To address the growing opioid epidemic, Empire implemented the Pharmacy Home Program in April 2016 to allow for better administration of drug benefits through increased communication and coordination amongst prescribing

physicians and pharmacies. The information in this section applies to Empire Members with our prescription drug coverage.

The Pharmacy Home Program helps reduce potential overutilization of prescription medications. If a Member is believed to be at an increased safety risk due to the overutilization of multiple medications, providers and/or pharmacies; and meets enrollment criteria they may be included in this program. Empire is able to increase communication and coordination amongst prescribing physicians for Members that have been identified and restricted to a single pharmacy. The pharmacy is selected by the Member and/or is assigned based on the retrospective Drug Utilization Review (“DUR”) of their prescription claims history. Following the selection of the Member’s new Pharmacy Home, all prescribing physicians receive notification of the Member’s enrollment into the program, the assigned pharmacy information and a 3-month prescription profile containing a list of all prescribers, medications, dosages, and quantities received by the Member during that timeframe.

The program is designed to limit a qualifying Member to the use of one specific participating pharmacy for a period of no less than 12 consecutive months. This assigned pharmacy, or Pharmacy Home, will fill all of the Member’s prescribed medications throughout the term of their enrollment in this program.

The Pharmacy Home Program includes:

- Reimbursement of Claims when filled at the Member’s Pharmacy Home. All pharmacy Claims¹
- are denied if filled at any pharmacy other than the Member’s assigned Pharmacy Home².
- Temporary overrides for urgent prescriptions.
- Access to Mail Order and Specialty pharmacies, in addition to the Pharmacy Home.

Criteria

A Member whose prescription Claims history shows they meet the below inclusion criteria may be enrolled in the Pharmacy Home Program if³:

- The Member received five or more controlled substance prescriptions (government-regulated drugs) in a 90-day period.
- The Member received controlled substance prescriptions from three or more prescribers in a 90-day period.
- The Member visited three or more pharmacies to fill controlled substance prescriptions in a 90-day period.

Communications to Members meeting criteria

Members who meet criteria are sent a notification at least 60 days prior to potential inclusion in the program. After a 60-day monitoring period, if the Member continues to meet the program criteria during that timeframe, he/she is contacted in writing of the decision to place him/her into the Pharmacy Home program and will be given 30 additional days to select a Pharmacy Home and/or to file an appeal of the decision. In the event the Member does not select a Pharmacy Home within the allotted timeframe, one will be chosen for the Member on the 31st day based off of their pharmacy Claims. Empire will ensure both the Member and their Provider will be notified of their new Pharmacy Home in writing. Once they have chosen a Pharmacy Home, a request to change pharmacies will be considered only for good cause situations.

Empire is more committed than ever to equipping Providers with the tools and support necessary to help curb these trends and save more lives than are lost. If you have any questions or comments

regarding enrollment, please contact the Member Services number located on the back of the Member's ID.

¹ Both controlled and non-controlled medications must be filled at the designated Pharmacy Home.

² A Member may change the designated pharmacy only if the request meets good cause criteria.

³ Exemption of members with a diagnosis of Cancer, HIV, Multiple Sclerosis, Sickle-cell Anemia or those that are in Hospice Care. (Note: Exemptions are determined by both pharmacy claim history and medical diagnosis.)

Appendix A

Americans with Disabilities Act

The Americans with Disabilities Act is a comprehensive civil rights law that prohibits discrimination on the basis of disability and includes a requirement that all facilities and services be accessible to individuals with disabilities. All providers are required to comply with the Americans with Disabilities Act in order to participate in Empire's provider networks.

Patient's Self-determination Act

Members have the RIGHT to:

- Make medical decisions.
- Accept or refuse treatment, including the right to refuse life-sustaining medical and surgical treatment.
- Make advance directives about their medical care in the event they cannot make decisions.

Members can learn more about their rights and responsibilities, and their rights under the Patient's Self-Determination Act by calling Member Services at the telephone number located on the back of their member identification card.

Assistance for Non-English Speaking Members

Empire strives to ensure that our HMO members who speak a language other than English are able to obtain assistance from our Member Services department. We do this by providing translation services to our members via an AT&T Language Line translator.

Confidentiality Policy

When a Member Services representative receives a call from someone who speaks a language other than English, the representative puts the caller on hold and calls the AT&T Language Line. The AT&T Language Line operator links the Member Services Representative and the caller to an interpreter in the appropriate language. Through a three-way connection, the interpreter facilitates the member's inquiry.

In recognition of the need for member privacy, and in compliance with federal and state laws and regulations, Empire has a policy on the confidentiality of member medical information.

- Empire has in place and enforces appropriate safeguards to protect the confidentiality, security and integrity of member medical information, which is used, disclosed, exchanged or transmitted orally, in writing or electronically.
- Confidential member medical information is accessible only to those Empire employees and authorized third persons who need it to perform their jobs. All persons are required to comply with Empire policies and procedures and federal and state laws and regulations concerning the

request for, the use, disclosure, transmission, security, storage and destruction of confidential member medical information.

- Empire does not disclose member nonpublic personal information, including member medical information, to any of our affiliates or to nonaffiliated third parties, except as permitted by law to allow us to conduct our business.
- Disclosure of confidential information to external vendors for purposes of payment or healthcare operations is made only in accordance with appropriate confidentiality agreements and contractual arrangements. Data shared with external entities for measurement purposes or research is released only in accordance with appropriate confidentiality agreements and contractual arrangements or in an aggregate form that does not allow for direct or indirect member identification.
- Member medical information is not shared with the member's employer, unless permitted or required by law. Because Empire is not a provider of medical services, it generally does not maintain medical records created by the member's provider of service. If a member requires access to his or her provider's medical records, the member should contact his or her provider to arrange access.
- Empire contractually requires all of its network practitioners and providers to comply with all state and federal laws regarding confidentiality of member records to ensure the privacy and to protect the confidentiality of members' medical information.
- When a member becomes covered under an Empire health benefit plan, the member agrees that Empire, or its designee, may use and/or disclose the member's confidential medical information for purposes of payment and healthcare operations as permitted or required by law or regulation. In addition, each Empire member agrees that any healthcare provider, healthcare pay or government agency shall furnish to Empire or its designee all records pertaining to medical history, services rendered and payments made for use and/or disclosure by Empire to administer the terms of the health benefit plan.
- A member may request access to information that is maintained by or for Empire by calling Customer Service to arrange access. A member may request an amendment of records maintained by and for Empire, or a member may request an accounting of disclosures as permitted by law. Members can call Customer Service for more information.
- Generally, under state and federal law (e.g., the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations), the use and disclosure of member medical information for purposes of treatment, payment and healthcare operations that occur between a provider and a health plan, clearinghouse, another provider, or other insurance carrier is permitted without the necessity of seeking an authorization from the member. For example, under HIPAA, determinations of medical necessity, appropriateness of care, justification of charges and utilization review activities are included within the definition of payment; and conducting quality assessment and improvement activities, reviewing the qualifications of healthcare providers and conducting fraud and abuse detection and compliance programs are included within the definition of healthcare operations.
- Except as stated above and as may be permitted or required by law, Empire does not release confidential member medical information to anyone outside Empire without a specific "written authorization" to release authorized by the member or member's designee, which may be revoked at any time. The authorization must be signed and dated and must specify:
 - The information that can be disclosed and to whom
 - What the information will be used for
 - The time period for which the authorization applies

Notice of Privacy Practices (as directed towards our members)

Empire respects the privacy and confidentiality of our member's medical information. Below is Empire's Notice of Privacy Practices, which summarizes Empire's Privacy Policy regarding our members. It is directed to, and was distributed to, our members in order to inform them of how information about them may be used and disclosed by Empire. This includes, but is not limited to, uses and disclosures for treatment, payment activities and healthcare operations. Empire encourages you and anyone in your practice that handles our members' health information to read the notice in order to become familiar with our privacy practices.

At Empire, we respect the confidentiality of your medical information and will protect that information in a responsible manner. We have a comprehensive privacy program in place that meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, the government legislation that sets standards for the privacy of medical information.

Empire follows all state privacy laws to which we are subject that do not conflict with the HIPAA Privacy Regulations. However, if a state privacy law conflicts with the HIPAA Privacy Regulations yet provides greater privacy rights or protections than the HIPAA Privacy Regulations, we will follow that state law. We must follow the privacy practices that are described in this notice while it is in effect. We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the changes are permitted by law. Before we make a significant change to our privacy practices, we will change this notice and send the new one to our current subscribers. This new notice will be effective for all medical information that we maintain, including medical information we created or received before the changes were made.

Additionally, please know that Empire is required by law to maintain the privacy of your medical information and to give you this notice regarding your rights, our privacy practices and legal duties concerning your medical information.

Definition of Medical Information

When Empire refers to medical information in this notice, we mean information that is individually identifiable health information. This includes demographic information collected from you or created or received by a healthcare provider, a health plan, your employer or a healthcare clearinghouse.

This information may relate to:

- Your past, present or future physical or mental health or condition;
- The provision of healthcare to you or
- Past, present or future payments for the provision of healthcare to you.

Uses and Disclosures of Medical Information

This section provides you with a general description and examples of the ways your medical information is used and disclosed. Empire's uses and disclosures are not limited to these examples.

Treatment: Your medical information may be disclosed to a physician or other healthcare provider in order for them to provide you with treatment.

Payment: Your medical information may be used or disclosed: for billing, claims management and collections activities.

- To pay claims from physicians, Facilities and other providers for services delivered to you that are covered by your health plan.
- To determine your eligibility for benefits. to conduct risk adjustment activities.
- To coordinate benefits.
- To determine medical necessity.
- To conduct utilization reviews.
- To obtain premiums.
- To issue explanations of benefits to the person who subscribes to the health plan in which you participate. To a healthcare provider or entity so they can obtain payment or engage in payment activities.

Healthcare Operations: Your medical information may be used and disclosed in connection with our healthcare operations, including

- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of benefit coverage.
- Case management and care coordination.
- Contacting healthcare providers and patients with information about treatment alternatives, disease management or wellness programs and related functions that do not include treatment.
- Population-based activities relating to improving health or reducing healthcare costs.
- Quality assessment and improvement activities and protocol development.
- Reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- Conducting or arranging for medical review, legal services, auditing and fraud and abuse detection and compliance programs.
- Business planning and development, such as formulary development and administration.
- Business management and general administrative activities, including management activities relating to privacy, customer service and resolution of internal grievances.

Additional Disclosures: Your medical information may be disclosed

- To another entity that has a relationship with you for their healthcare operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, or detecting or preventing healthcare fraud and abuse.
- To other persons or entities that assist us in conducting our payment, healthcare operations and business activities. Please know that we will not disclose your medical information to those persons or entities unless they agree to keep it protected.

Health-Related Services: Your medical information may be used to send you appointment reminders or to communicate with you in order to encourage you to purchase or use a health-related product or service (or payment for such product or service), that is provided by, or included in, an Empire health plan.

This includes communications about:

- The entities participating in a healthcare provider network or health plan network;
- The replacement of, or enhancements to, a health plan
- Any health-related products or services available only to a health plan enrollee that add value to, but are not part of, a benefit plan, for purposes of treatment, case management or care

coordination, or to direct or recommend alternative treatments, therapies, healthcare providers or settings of care.

To Your Family and Friends: Your medical information may be disclosed to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Your name, location and general condition or death may be used or disclosed to notify or assist in the notification of (including identifying or locating) a person involved in your care.

We will provide you with an opportunity to object to such uses or disclosures, unless, based on professional judgment, we may reasonably infer from the circumstances that you do not object to such uses and disclosures.

If you are not present, or in the event of your incapacity or an emergency, we will use our professional judgment in deciding whether disclosing your medical information would be in your best interest.

If You Are a Member of a Group Health Plan:

Your medical information, and the medical information of others enrolled in your group health plan, may be disclosed to your employer or the organization that sponsors your group health plan (the “plan sponsor”) in order to permit the plan sponsor to perform Plan administrative functions. Please see your Plan documents for an explanation of these limited uses and disclosures.

Summary information about the enrollees in your group health plan may also be disclosed to the plan sponsor so they may obtain premium bids for health insurance coverage or in order to decide whether to modify, amend or terminate your group health plan. The information we may disclose summarizes claims history and expenses or types of claims experienced by the enrollees in your group health plan. This summary information will be stripped of demographic information but the plan sponsor may still be able to identify you or other enrollees.

Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by its charter or by law to assist in disaster relief efforts.

For the Public Benefit: Your medical information may be used or disclosed as authorized by law for the following purposes:

- As required by law
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight and to employers regarding work-related illness or injury
- To report adult abuse, neglect or domestic violence
- To health oversight agencies in response to court and administrative orders and other lawful processes
- To law enforcement officials pursuant to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and for purposes of identifying or locating a suspect or other person
- To coroners, medical examiners and funeral directors to organ procurement organizations
- To avert a serious threat to health or safety in connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities

- To correctional institutions regarding inmates as authorized by state workers' compensation law

Marketing: Your medical information may be used or disclosed by us to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts of nominal value.

Fundraising: Your demographic information and the dates of healthcare services provided to you may be used in order to contact you for fundraising. We may disclose information to a business associate or foundation to assist us in our fundraising activities. We will provide you with fundraising materials and a description of how you may opt out of receiving future fundraising communications.

Times When Your Written Authorization Is Required:

Other uses and disclosures of your medical information that are not described above will only be made with your written authorization. You may give us written authorization to use or to disclose your medical information to anyone for any purpose.

You may revoke your authorization at any time. However, your revocation will not affect any use or disclosure that you permitted prior to your revocation.

Your Individual Rights (as directed towards our Members)

Access to Your Information:

You have the right to inspect or obtain a copy of the medical information about you that is contained in a "designated record set" except for psychotherapy notes and certain other information. A "designated record set" generally contains medical and billing records as well as other records that are maintained by or for us, or used by or for us to make decisions about you.

We may ask you to submit your request in writing and to provide us with the specific information we need in order to fulfill your request. We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies to you. In certain situations, we may deny your request to inspect or obtain a copy of the requested information. If we deny your request, we will notify you in writing and may provide you with an opportunity to have the denial reviewed.

Accounting of Disclosures:

You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, healthcare operations or those authorized by you as well as for certain other activities that occurred up to six years before the date of your request. However, you will not be able to obtain a list of disclosure instances that occurred prior to April 14, 2003, the date this notice is effective. Any list we send you will include the date(s) of the disclosure, to whom it was made, their address, if known, a brief description of the information disclosed and the purpose of the disclosure. If you request this accounting list more than once in a 12-month period, we may charge you a reasonable administration fee for these additional requests.

Restrictions on Use or Disclosure:

You have the right to request that we restrict the use or disclosure of your medical information in connection with treatment, payment and healthcare operations. You also have the right to request that we restrict disclosures to persons involved in your healthcare or payment for your healthcare. We may ask you to submit your request in writing. We will review your request, but we are not required to

comply with it.

Confidential Communication:

You have the right to request that we communicate with you about your medical information by a different means or location. You must make your request in writing and state that the information could endanger you if it is not communicated by a different means or location. We must accommodate your request if it is reasonable and specifies the new means or location of contact. It must also allow us to collect premiums and pay claims. This includes issuing explanations of benefits to the subscriber of the health plan in which you participate.

An explanation of benefits issued to the subscriber about the subscriber or others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained healthcare for which we paid, even though we communicated with you in the confidential manner you requested. Once your request for confidential communications is in effect, all of your medical information will be communicated in accordance with your instructions.

Amending Your Medical Information:

If you believe that the medical information contained in your “designated record set” is not correct or complete, you have the right to request that we amend it. We may require your request be in writing and that it explains why the information should be changed. If we make the amendment, we will notify you. In addition, if we make the change, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

If your request is denied, you will be notified in writing of the reason for the denial and the letter will explain how to file a written statement of disagreement. Empire has the option to rebut your statement. You have the right to ask that your original request, our denial and your statement of disagreement be included with any future disclosures of your information.

Requests for Additional Copies and Questions Regarding Privacy and Individual Rights:

- You may request a copy of our notice at any time.
- If you view this notice on our website or receive it by e-mail, you are also entitled to receive it in written form.
- You may request more detailed information about your rights and privacy protections or learn how to exercise those individual rights as described in this notice.

Please contact Empire Member Services at the phone number listed on the back of your member identification card or write to us at
PO Box 1407, Church Street Station
New York, NY 10008-1407.

Complaints:

If you believe that Empire has violated your privacy rights, write to our Privacy Office at PO Box 1407, Church Street Station, New York, NY 10008-1407 or call Empire Member Services at the phone number listed on the back of your member identification card. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become

aware of the problem. We will provide you with this address upon request. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. We support your right to the privacy of your medical information.

Notice of Privacy Practices (as directed towards our Members)

HIPAA NOTICE OF PRIVACY PRACTICES

Effective July 1, 2007

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment:

We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.
For Health Care Operations:

We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities:

We do not provide treatment. This is the role of a health care provider such as your doctor or a Facility. But, we may share PHI with your health care provider so that the provider may treat you.

To You:

We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others:

You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not

present, if it is an emergency, or you are not able to tell us it is OK

We may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law:

We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Your Rights:

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We

require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

State Notice of Privacy Practices

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.

We may collect PI about you from other persons or entities such as doctors, Facilities, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Confidentiality of HIV Information

Providers are reminded that they are obligated by law to comply with the confidentiality restrictions of Public Health Law Article 27-F and Section 2784, dealing with patient-specific information related to HIV infection.

Providers are also reminded of the following requirements.

Providers shall develop policy and procedures to assure confidentiality of HIV related information. The policy and procedures must include:

- Initial and annual in-service education of staff, contractors
- Identification of staff allowed access and limits of access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling for HIV/related information
- Protocols to protect person with or suspected of having HIV infection from discrimination

Providers are also reminded of the following requirements.

- Required HIV pre-testing counseling with clinical recommendation of testing for all pregnant women. Those women and newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social, and addictive services.