SANTÉ PHYSICIANS

CUSTOMER SERVICE
* Overview

The Customer Service Department is an integral part of the Santé Physicians' commitment to service. This department services two types of customer: HMO members and physicians and their office staff or billing services.

HMO Members
Examples of the role of the Santé Customer Service Department for HMO members are:

1. Redirect eligibility inquiries to member's designated health plan.
2. To provide members with physician rosters.
3. Redirect
4. To assist in claim inquiries, ancillary provider selection, and current physician roster information.
5. To facilitate prompt payment of claim problems.
6. To educate as needed.

The Customer Service telephone number for HMO members is listed below.

For:	Call:
Members	(559) 228-5410

Physicians, Office Staff, Billing Services
Examples of the role of the Santé Customer Service Department for physicians, office staff, and billing services are:

1. To provide member eligibility based on tapes received monthly from HMO plans.
2. To provide verification of PCP assignment as received from the member's HMO plan.
3. To assist in claim inquiries, ancillary provider selection, and current physician roster information.
4. To facilitate prompt payment of claim problems.
5. To educate as needed.

Customer Service telephone number for Physician Offices is listed below.

For:	Call:
All PCP and Specialty Offices	(559) 228-5410

CUSTOMER SERVICE
* Overview (Continued)

Patient Billing Statements from Physician Offices or Surcharges

Santé's HMO contracts authorize all patient billings to be limited to the following:

- Co-payments
- Deductibles
- Non-covered services

Patient "Statements" are not authorized and should not be sent. Surcharges of any kind are also prohibited. If a physician office is sending patients a statement showing full charges or a surcharge has been imposed, they will be considered out of compliance with both the HMO contract and the Knox-Keene Health Care Service Plan Act.

(If you have been notified that a patient is not eligible on an HMO, you may bill the patient at that time.)

For any claim issue, physician offices should work directly with Santé's Customer Service Department, where our staff is dedicated to working with both PCP and Specialty Physician offices.

Copayments

A copayment is an additional fee charged to an HMO patient that is approved by the applicable state and federal regulatory authority. Copayment amounts vary between plans and depend on the services the member receives. Copayment information is usually listed on the members ID card and should be collected at the time professional services are rendered.

Copayments – Unpaid

If a patient shows up for an appointment without the required copayment, the physician office may:

- Bill the patient at a later date
- Reschedule any non-urgent appointment when copayment is available

If a patient fails to pay an outstanding copayment, the physician office may:

- Send the patient to collections
- Reschedule any non-urgent appointment when copayment is available
- Discharge the patient from your practice (30 day notice is required)
- Contact Santé Customer Service who will request Santé's QI Department to counsel the member if routine collection methods have been exhausted.

Physician offices may not impose a surcharge or interest on any copayment not paid at the time of service.

CUSTOMER SERVICE
* Overview (Continued)

Copayments – Missed Appointment

A copayment may not be collected for a missed appointment.

Copayments – Patients With Two Santé HMOs

When a Santé Physicians provider sees an insured patient under two Santé HMOs, Santé will reimburse the physician according to contract (FFS or CAP) with the first HMO. When coordinating benefits under the second HMO, the copay will be processed according to contract (FFS or CAP). Therefore, no copay should be collected. Providers under Primary Care Physician capitation or full capitation will receive two capitation amounts on that patient in lieu of a FFS copayment.

Waiver of Liability

HMO members must be properly informed in advance and in writing of services or procedures that are not covered by their benefit plan. If they choose, have the HMO member sign a waiver agreeing to pay for non-covered services. If the provider does not obtain a signed waiver of liability, and the care is unauthorized by Santé, the provider is expected to accept full liability for the cost of the service or procedure.

Examples of possible non-covered services are:

- Removal of Skin tag
- Diet Instruction
- Immunization not on member's benefit list

In the event the member chooses to upgrade a product or service, by signing the waiver the member is agreeing to pay the difference between the billed and allowed amount. If the provider does not obtain a signed waiver of liability, the provider is expected to accept the allowed amount as payment in full.

Example of an upgraded item includes but not limited to:

- FluMist

Following is an example Waiver of Liability form: you may choose to use your own form with similar language. Once signed, this form is to remain in the patient file and it is not necessary to mail to Santé with the claim.

CUSTOMER SERVICE
* (Continued)

How to Change Primary Care Physicians
When a member wants to change from one PCP to another, notification must be made through the HMO plan's Customer Service Department. Toll-free numbers are listed on the member's ID card. (Members may also notify the HMO in writing.)

Eligibility Reports
Eligibility reports are available to download from Santé's website at www.santehealth.net. This report combines all HMO plans into one alphabetized list of members for easy reference. A secure log-in is required to obtain this information. If you do not have a log-in, please go to www.santehealth.net and click on "Providers/Administrators" then click on "Sign-Up".

HMO Eligibility Verification and Copayments
On occasion, new patients who are not listed on the Eligibility Report may come to a PCP office seeking care. The provider office should ask patients to provide a current HMO identification card or documentation from their employer before rendering services.

It is recommended the provider collect the most current insurance ID card. Most ID cards indicate PCP assignment and copayment amount. However, the provider office should verify the member's PCP assignment, eligibility and copayment amount by calling the HMO corporate office at the phone number located on the back of the member's ID card or by obtaining log-in access to the health plan websites for quick verification.

Health Plan websites are as follows:

• Aetna	www.aetna.com
• Anthem BlueCross	www.bluecrossca.com
• Blue Shield	www.mylifepath.com
• Brand New Day	www.bnd.com
• CIGNA	www.cigna.com
• CCH	www.cchealthplan.org
• Health Net	www.healthnet.com
• Health Net Healthy Hearts	www.healthnet.com
• UnitedHealthcare Signature Value HMO (Formerly PacifiCare Commercial HMO)	www.uhcwest.com
• AARP Medicare Complete (Formerly Secure Horizons)	www.uhcmedicaresolutions.com/health-plans/medicare-advantage-plans
• UnitedHealthcare Medicare Solutions: Group Retiree (Formerly Secure Horizons)	www.uhcmedicaresolutions.com/health-plans/medicare-advantage-plans

Santé Physicians

WAIVER OF LIABILITY FORM

MEMBER NAME: ____ **DOB:** _______________

SUBSCRIBER ID: _______________________ **GROUP NO:** __________________________

PROVIDER: ____

Provider: This form is to be used for HMO members who wish to receive health care services from you that may not be covered by their HMO Benefit Plan.

Member: Your signature on this form acknowledges that you agree to bear financial responsibility for all services provided as listed below if:

- the service(s) is not covered under your benefit plan, or,
- the service(s) has not been otherwise approved for payment by your health plan, or
- the service(s) is not medically necessary, or
- the service(s) is primarily for comfort and convenience, or,
- You choose to upgrade a product or service above the level otherwise covered under your health plan (you will pay the difference between the billed and allowed amount)

Services: (Any service not described as a covered benefit in the member's Evidence of Coverage Disclosure Form)

Date of Service	Service, Product, or Upgrade	Total Cost	Member's (patient's) Responsibility*

*In addition to being responsible for this amount, I understand that I will be billed and held responsible for any applicable copayment or deductible.

____
Patient Name

________________________________ ______________
Signature of Patient/Guardian **Date**

________________________________ ______________
Signature of Witness **Date**

LANGUAGE ASSISTANCE PROGRAM

SB853
Language Assistance Program

On January 1, 2009 all Commercial HMO's (non-Medicare) contracted with Santé Physicians will be required to provide a Language Assistance Program for providing services to their limited English proficient enrollees free of charge. Services include interpretation and translation.

The Language Assistance Program is designed to meet the growing needs of our state's population as well as the health membership of each of the plans.

The following is an outline of what the Language Assistance Program entails:

Language Assistance Program

Service Offered	Guidelines
Interpreter services provided at all points of contact	• Professional interpreters are proficient in health care terminology • Professional interpreters receive training regarding HIPPA (confidentiality) and ethical standards • Points of contact include administrative, clinical, and related services
Written materials that are provided in the threshold languages	• Materials translated prospectively include enrollment, eligibility and membership information, EOBs, and notices of language assistance. • Members must indicate their preferred written language to receive prospectively translated materials
Written materials are translated into a threshold language upon request	• Materials that are member-specific (e.g., denial, delay or claims letters) are sent in English with the offer of translation upon request • Translated materials are sent to the member no later than 21 days from the request date • Translators are proficient in health care terminology • Translators received training regarding HIPAA (confidentiality) and ethical standards

(Continued)

What is a threshold language?

A threshold language is a language other than English that is spoken by the proportion of the health plan's enrollees. The health plans are required to provide interpretation and translation services for their identified threshold languages at a minimum.

Plan Threshold Languages

Plan	Languages
Aetna	Spanish
Anthem Blue Cross	Chinese (traditional), Korean, Spanish, Tagalog, Vietnamese
Blue Shield	Chinese (traditional), Spanish, Vietnamese
Cigna	Chinese (traditional), Spanish
Community Care Health	No Threshold Language
Health Net	Chinese (traditional), Spanish
UnitedHealthcare (Formerly PacifiCare)	Chinese (traditional), Spanish

Accessing Interpreter Services by Plan

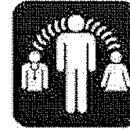
Plan	Type of Interpretation	Plan Interpreter Access
Aetna	Telephonic ……………………	800-525-3148
Anthem Blue Cross	Telephonic ……………………	800-677-6669
Blue Shield	Telephonic …………………… In Person……………………..	800-541-6652 Fax Language Assistance Form to 209-371-5838 with a 5 day notice
Community Care Health Plan	Telephonic……………………	866-874-3972 Use client ID # 298699
Cigna	Telephonic ……………………	800-806-2059
Health Net	Telephonic ……………………	800-522-0088 – Commercial 800-977-3073 – Healthy Families/Kids
UnitedHealthcare (Formerly PacifiCare)	Telephonic ……………………	800-730-7270 – Spanish 800-938-2300 – Chinese 800-624-8822 – All other

Please note: Some plans may provide interpreter services for more languages than their identified threshold languages. Just ask when you call the above numbers.

Accessing Translation Services by Plan

Plan	Plan Translation Access
Aetna	877-287-0117
Anthem Blue Cross	888-254-2721
Blue Shield	Fax Language Assistance Form to 209-371-5838
Community Care Health	855-343-2247
Cigna	Culturalandlinguisticsunit@cigna.com
Health Net	800-522-0088
UnitedHealthcare (Formerly PacifiCare)	800-730-7270 – Spanish 800-938-2300 – Chinese 800-624-8822 – All other

Tips for Working with Limited English Proficient (LEP) Members



- **California law** requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

- **Who is a LEP member?**
  Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP).

- **How to identify a LEP member over the phone**
  - Member is quiet or does not respond to questions
  - Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions
  - Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate
  - Member self identifies as LEP by requesting language assistance.

- **Tips for working with LEP members and how to offer interpreter services**
  1) Member speaks no English and you are unable to discern the language
     → Connect with contracted telephonic interpretation vendor to identify language needed.

  2) Member speaks some English:
     → Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.

     → How to offer interpreter services:
     "*I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?*"

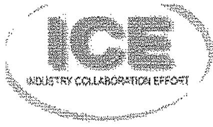
     Or

     "*May I put you on hold? I am going to connect us with an interpreter.*" (If you are having a difficult time communicating with the member)

- **Best practice to capture language preference**
  For LEP members it is a best practice to capture the members preferred language and record it in the plan's member data system.
  "*In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?*"

*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at: http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

ICE Approved: 6/27/08



Tips for Working with Interpreters

Telephonic Interpreters

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey. *
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, e.g., "can't - cannot." *
- Speak in short sentences, expressing one idea at a time.*
- Speak slower than your normal speed of talking, pausing after each phrase.*
- Avoid the use of double negatives, e.g., "If you don't appear in person, you won't get your benefits." * Instead, "You must come in person in order to get your benefits."
- Speak in the first person. Avoid the "he said/she said." *
- Avoid using colloquialisms and acronyms, e.g., "MFIP." If you must do so, please explain their meaning.*
- Provide brief explanations of technical terms, or terms of art, e.g., "Spend-down" means the client must use up some of his/her monies or assets in order to be eligible for services." *
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client. *
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way. *
- ABOVE ALL, BE PATIENT with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service. *
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room. The following will help the interpreter do a better job. **

- When the interpreter comes onto the line let the interpreter know the following: **
  - Who you are
  - Who else is in the room
  - What sort of office practice this is
  - What sort of appointment this is

  For example, "Hello interpreter, this is Dr. Jameson. I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam." **
- Give the interpreter the opportunity to introduce himself or herself quickly to the patient. **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it. **

On-site Interpreters

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.

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- For face-to-face interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained. For sign language (ASL) interpreting, it is best to position the interpreter beside the patient so the patient can capture the hand signals easily.
- Be aware of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- Be attentive to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, "yes" may not always mean "yes." Instead, "yes" might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment, or simply a polite way of declining to give a definite answer at that juncture.
- Greet the patient first, not the interpreter. **
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today." **
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's "voice" most accurately and deal with the patient directly. **
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult. **
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything. **
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter. **
- Speak in: Standard English (avoid slang) **
    - Layman's terms (avoid medical terminology and jargon)
    - Straightforward sentence structure
    - Complete sentences and ideas
- Ask one question at a time. **
- Ask the interpreter to point out potential cultural misunderstandings that may arise. Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. **
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. **
- Avoid interrupting the interpretation. Many concepts you express have no linguistic, or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use. This may take longer than your original speech. **
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education. **
- Acknowledge the interpreter as a professional in communication. Respect his or her role. **

Footnotes:

** **"Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website.**

* **"Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).**

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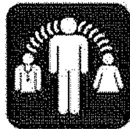

Tips for Documenting Interpretive Services
for Limited English Proficient (LEP) Patients:
Notating the Provision or the Refusal of Interpretive Services

California law requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

- **Documenting refusal of interpretive services** in the medical record not only protects you and your practice, it also ensures consistency when your medical records are monitored through site reviews/audits by contracted health plans to ensure adequacy of the plan's Language Assistance Program.
  - It is preferable to use professionally trained interpreters and to document the use of the interpreter in the patient's medical record.
  - If the patient was offered an interpreter and refused the service, it is important to note that refusal in the medical record for that visit.
  - Although using a family member or friend to interpret should be discouraged, if the patient insists on using a family member or friend, it is extremely important to document this in the medical record, especially if the chosen interpreter is a minor.
    - Smart Practice Tip: Consider offering a telephonic interpreter *in addition* to the family member/friend to ensure accuracy of interpretation.
  - For all LEP patients, it is a best practice to document the patient's preferred language in paper and/or electronic medical records (EMR) in the manner that best fits your practice flow.*
    - For a paper record, one way to do this is to post color stickers on patient's chart to flag when an interpreter is needed. (For example: Orange = Spanish, Yellow = Vietnamese, Green = Russian)*
    - For EMRs, contact your IT department to determine the best method of advising all health care team members of a preferred spoken language.

**Source: Industry Collaboration Effort (ICE) Tips for Communicating Across Language Barriers; www.iceforhealth.org*

***The universal symbol for interpretive services at the top left of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at: http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw*

ICE Approval: 6/20/08

blue of california

Language Assistance Request Form

Fax to: Blue Shield Translation Liaison at **(209) 371-5838**

Number of pages (including cover) = ☐

RE: Language Assistance Request on behalf of a Blue Shield Member.
Use this form for enrollees of Blue Shield of California or Blue Shield of California Life & Health Insurance Company.

This is a request for written translation of specific document(s) only

Date of request:	
From: (Name and organization):	Phone number:
Subscriber I.D. Number:	Subscriber name:
Patient Name:	Patient date of birth:
Requested Language:	Patient contact phone number:
If our Translation Liaison has questions, whom should we contact?	Provider contact number:
Brief description of document to be translated (please attach copy of document):	
☐ **This request is urgent.** Note: Providers must forward request from member to Blue Shield within one business day. ☐ **This request is non-urgent.** Note: Providers must forward request from member to Blue Shield within two business days.	
Please notify me at ______________ when this request has been fulfilled. (phone number where we can reach you) ☐ Yes ☐ No	

This facsimile transmission may contain protected and privileged, highly confidential medical and/or legal information. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate or otherwise distribute it. If you are not the intended recipient, please immediately notify the sender. Blue Shield of California will arrange to retrieve the fax at no cost to you. Thank you for your help in maintaining appropriate confidentiality.

Blue Shield of California
50 Beale Street, San Francisco, CA 94105

blueshieldca.com

An Independent Member of the Blue Shield Association

CLAIMS
* Submission Guidelines

Claim Form
Use of the HCFA -1500 form *(sample follows)* is required to process your claim.

- Indicate the HMO plan on the top of the form;
- Identify the member's name, address, and identification numbers, and/or include a copy of the member's plan identification card;
- Include any other insurance information so that we may coordinate benefits;
- If appropriate, indicate on the claim document if you were providing services for another physician on an "on-call" basis, for proper benefit determination.
- Identify services rendered using CPT codes;
- For injections use J codes, specifying units provided.

Claims Submission Timeline:
Claims must be submitted promptly to avoid the possibility of forfeiture of payment for services. Please note that the Santé HMO contract specifies if a claim is denied due to late provider claims submission, the charges are not the financial responsibility of the patient.

- HMO claims must be received within 90 days of the date of service**.**
- For claims in which SP/HMO is secondary, claims must be submitted within 90 days from the "processed date" as noted on the explanation of benefits from the primary carrier.

Submit HMO claims to:
Santé Physicians
(HMO name here, example: Health Net)
P.O. Box 1507
Fresno, California 93716-1507

(Some POS plans require claim submission to Santé, when patient is utilizing the HMO side of the POS plan: see Non-HMO Contracted Payor List on page 502.1)

CLAIMS
* Submission Guidelines (continued)

Claims Inquiry
The follow-up process should be initiated if claim notification (payment, denial, or explanation) is not received from Santé within 60 days of initial claim submission:

- PCP and Specialty offices should call the Customer Service Department for claims inquiry.
- For claims not resolved, resubmit with "TRACER" clearly marked on the face of the resubmitted claim, to distinguish it from original submissions.

TRACER claims must be received within 150 days from the date of service, and be submitted on a HCFA 1500 Form.

Provider Inquiry Request Form
The Provider Inquiry Request form on the following page may be used to:
- ♦ Resubmit a contested claim, submitting missing information
- ♦ Check status of claim(s)
- ♦ Request clarification on calculation of payment
- ♦ Request assistance in determining member responsibility
- ♦ Submit corrected billing

Submit Provider Inquiry Request form to:

Provider Inquiry
Santé Physicians
P.O. Box 792
Fresno, CA 93712

PROVIDER INQUIRY REQUEST

Send to:
Provider Inquiry
Santé Physicians
P.O. Box 792
Fresno, CA 93712

Sent by: (provider name/facility)	Provider Tax ID #:
Provider Address:	

Patient Name:		Date of Birth:
Member ID Number:	Claim Number (if known):	
Service “From – To” Date:	Original Claim Amount Billed:	Original Submission Date:

INDICATE REASON FOR INQUIRY AND PROVIDE A DETAILED DESCRIPTION:

Inquiry Type:

☐ Resubmission of “contested” claim with missing information. (documentation attached)

☐ Status of Claim (i.e., no receipt of payment)

☐ Clarification on calculation of payment

☐ Assistance in determining member responsibility

_______________________ _______________________ _______________________
Contact Name (Print) Title Phone Number

_______________________ _______________________
Signature Date

CLAIMS
* Electronic Claims Submission Guidelines

Submission Guidelines
Claims must be submitted promptly to avoid the possibility of forfeiture of payment for services. Please note that the Santé HMO contract specifies if a claim is denied due to late provider claims submission, the charges are not the financial responsibility of the patient.

- HMO claims must be received within 90 days of the date of service**.**

When Santé HMO is Secondary
For claims in which Santé HMO is secondary, claims must be submitted within 90 days from the “processed date” as noted on the explanation of benefits for the primary carrier. These claims must be submitted hardcopy on a HCFA – 1500 form with the primary carrier’s explanation of benefits.

Claims Inquiry
The follow-up process should be initiated if claim notification (payment, denial, or explanation) is not received from Santé within 60 days of initial claim submission:

- PCP and Specialty offices should call the Customer Service Department for claims inquiry. Or;
- Claims inquiry can be made via the Santé web site at www.santehealth.net (office manager or provider access is required. See page 603.9 for instructions on how to gain web site access).
- For claims not resolved, resubmit a hardcopy claim by clearly marking “TRACER” on the face of the resubmitted claim, to distinguish it from original submissions along with supporting documentation (i.e. billing confirmation report or billing history).

TRACER claims must be received within 150 days from the date of service, and be submitted on a HCFA 1500 Form.

If You Are Interested In Submitting Your Claims Electronically

Contact Santé’s customer service at (559) 228-5410.

CLAIMS
* Provider Dispute

A provider dispute is a written notice challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted, contested, or seeking resolution of a billing determination or other contract dispute.

Each provider dispute **must** contain, at a **minimum,** the following information:

- The providers name, address and phone number
- Providers identification number
- A clear identification of the disputed item including date of service
- A complete and accurate explanation of the issue
- If the provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue

Provider disputes for medical inappropriateness will be reviewed by the Medical Director or the Associate Medical Director.

Time Limitations for Submission of Provider Disputes
The physician has 365 calendar days from the date of denial notification to submit a provider dispute.

Provider Dispute Address
Provider disputes must be submitted with a formal written letter explaining the circumstances as to why the denial should be reviewed for reconsideration. The use of the following *Provider Dispute Resolution Request* form may be used in lieu of a letter.

Submit Provider Disputes to:

Attention: Santé Customer Service/Appeals

Via Mail: P.O. Box 792, Fresno, CA 93712
or
Via Physical Delivery: 7370 N. Palm Ave. #101, Fresno, CA 93711
or
Via Fax: (559) 224-2672

PROVIDER DISPUTE RESOLUTION REQUEST

Send to:
Santé Customer Service/ Appeals
P.O. Box 792, Fresno, CA 93712
Or
Fax to:
(559) 224-2672

Provider Name:	**Provider Tax ID #:**
Provider Address:	**Contracted?** ☐ **Yes** ☐ **No**

Patient Name:		**Date of Birth:**
Social Security Number:	**Subscriber ID #:**	**Claim Number:**
Service "From – To" Date:	**Original Billed Amount:**	**Claim Amount Paid:**

Claim Information: ☐ Single Claim ☐ Multiple "LIKE" claims (attach spreadsheet)

Dispute Type: ☐ claim ☐ Appeal of Medical Necessity ☐ Contract Dispute ☐ Seeking Resolution of a Billing Determination ☐ Disputing a Request for Reimbursement of Overpayment ☐ Other

Description of Dispute: (INDICATE REASON FOR DISPUTE, PROVIDER'S POSITION AND BASIS THEREFOR) Additional paper can be attached if necessary

Expected Outcome: (please provide by claim if multiple)

Contact Name (Print)	Title	Area code & Phone Number
Signature and date	Email Address	Fax Number

CLAIMS
* Overpayments

Santé's policy on Claims Overpayments is to "take back" overpayments from future charges. Full itemization will be reflected on the remittance advice.

According to California Law, Santé has 365 days from date of payment to recover an overpayment. Santé is not restricted by the 365-day time limit if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.

If the provider contests the overpayment "take back", the provider, within 30 business days of the date of the remittance advice, must submit a written notice stating the basis upon which the provider believes that the claim was not overpaid. In this case, Santé treats the claim overpayment dispute as a provider dispute.

Please reference previous page for the *Provider Dispute Resolution Request* form.

CLAIMS
* Injectable Medications and Immunizations

The billing procedure for injectable medications and immunizations is the same. The only difference is the use of "J Codes" for injectables and appropriate "CPT Codes" for immunizations. ("J Codes" are described in the HCPCS Level II Code Book.)

The following administrative fees will be reimbursed regardless if billed with or without an E&M service:

CPT Code	Fee Schedule
90465	$19.98
90466	$10.43
90467	$ 6.00
90468	$ 6.00
90471	$19.98
90472	$10.43
90772	$ 6.00
90788	$ 6.00
90779	$ 6.00

Reminder:

Injections are reimbursed based on Average Wholesale Price (AWP) amounts, which have been calculated based on the actual description of the J Code. In order to properly reimburse, the quantity field on the HCFA 1500 form must be completed to reflect the dosage.

Example: J0696 Injection, ceftriaxone sodium, per 250 mg
(Rocephin)
500 mg given
Indicate 2 units in field 24G on HCFA 1500 form

Example: J1100 Injection, dexamethosone sodium phosphate, up to 4 mg/ml
(Decadron)
24 mg given
Indicate 6 units in field 24G on HCFA 1500 form

CLAIMS
* Chemotherapeutic Agents Delivered Parenterally (In Office)

Santé Physicians will reimburse physicians for cancer chemotherapeutic medications that are the financial liability of the IPA at the contract rate. Please supply the name, amount, strength, and the manufacturer of the drug when requesting compensation.

Billing for Supplies "Incident to" Office Visits or Surgical Procedures
The CPT Code Guide identifies supplies usually included in an office visit. Surgical trays are included in the surgical reimbursement. It is the policy of Santé to conform with the inclusive CPT code, and therefore miscellaneous supplies, such as gauze pads, alcohol preps, etc., and activities, such as mixing drugs, will not be further reimbursed beyond the CPT reimbursement.

IN-OFFICE LABORATORY REIMBURSEMENT
* For Non-Capitated Primary Care & Specialty

CPT	Service Code Description
80198	Theophylline
81000	Urinalysis by dip stick or tablet reagent; non-automated, with microscopy
81002	Urinalysis; non-automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81015	Urinalysis; Microscopic only
82273	Blood, occult, other sources, qualitative
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose; blood, reagent strip
83150	Homovanillic acid (HVA) (Quick Strep)
84703	Gonadotropin, qualitative
85007	Differential WBC count; manual (includes RBC morphology and platelet estimation)
85014	Blood count; other than spun hematocrit
85022	Blood count; hemogram, automated and manual differential WBC count (CBC)
85023	Blood count; hemogram and platelet count, automated, and manual differential WBC count (CBC)
85024	Hemogram & platelet count; automated/automated partial differential WBC count (CBC)
85025	Hemogram and platelet count; automated, and automated complete differential WBC count (CBC)
85044	Blood count; reticulocyte count, manual
85102	Bone marrow biopsy, needle or trocar
85590	Platelet; manual count
86308	Heterophile Antibodies; screening
86317	Immunoassay for infectious agent, antigen, or antibody; each (quick strep)
86403	Particle agglutination; rapid test for infectious agent; each antigen (strep test)
86490	Skin test; coccidioidomycosis
86580	Skin test; tuberculosis, intradermal
86585	Skin test; tuberculosis, tine test
87070	Culture, bacterial; any other source except urine, blood or stool, with isolation and presumptive identification of isolates
87081	Culture, presumptive, pathogenic organisms, screening only
87101	Culture fungi (mold or yeast) isolation, with presumptive identification of isolates; skin hair, or nail
87102	Culture, bacterial; other source (except blood)
87205	Smear; primary source, with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87210	Smear, primary source with interpretation; wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)
87340	Hepatitis B surface antigen (HBsAG)
89190	Nasal smear for eosinophils

All other laboratory services must be sent to Quest Diagnostic Laboratory.

CLAIMS – SPECIFIC POLICIES
* Processing Guidelines

Claims that are the risk of Santé Physicians are processed utilizing the National Correct Coding Initiative (NCCI) guidelines; edits developed by the Centers for Medicare Services (CMS). Additionally, claims payment determination is in accordance with Medicare guidelines unless specified otherwise in the provider contract agreement.

CLAIMS – SPECIFIC POLICIES
* Assistant Surgeon Reimbursement

Surgeons are required to utilize Santé contracted providers as surgical assistants. With the exception of emergency surgeries, prior authorization is required if a non-contracted provider must be utilized as a surgical assistant. In addition to prior authorization, the surgeon will explain the Santé *Assistant Surgeon Reimbursement* policy to the prospective assistant and affirm the assistant's adherence to that policy. Non-contracted assistant surgeons will not be permitted to balance bill Santé patients; such unpaid balances will be considered a matter between the surgeon and the surgical assistant. If the Non-contracted assistant surgeon balance bills a Santé HMO patient, Santé will be obligated to pay the balance of the charges. In this case, reimbursement will be debited from the surgeon's future reimbursements, not to exceed $1000.

Contracted Physician Surgical Assistants shall be reimbursed at a rate of 16% of the allowable surgical units based upon contract type. The patient may not be balanced billed for the difference between billed amount and paid amount.

Contracted non-physician Surgical Assistants, who are not reimbursed by the surgeon as employees, shall be reimbursed at a rate of 8% of the allowable surgical RBRVS units or units based upon contract type. The patient may not be balance billed for the difference between billed amount and paid amount.

Prior authorization is not required for non-physician Surgical Assistants who are reimbursed by the surgeon as employees. However, the surgeon will not bill Santé for the reimbursement of these assistant surgeon fees.

These Assistant Surgeon guidelines were developed utilizing Medicare guidelines.

(continued next page)

CLAIMS – SPECIFIC POLICIES
* Assistant Surgeon Reimbursement (continued)

Assistant surgeon fees **ARE ALLOWABLE** on the following procedures and do **NOT REQUIRE** prior authorization when utilizing a Sante contracted assistant surgeon:

12018	21422 - 21436	24100 - 24102	25490 - 25492	26686	27870 - 27881	29894 - 29899
12047	21445	24115 - 24116	25515	26820	27888	29904 - 29907
12057	21462 - 21470	24125 - 24126	25525 - 25526	26842 - 26844	27894	30125
15750 - 15758	21490 - 21495	24134	25545	26852	28086	30160
15770	21502	24138 - 24140	25574 - 25575	26862	28100 - 28107	30410
15830 - 15832	21557 - 21750	24149 - 24152	25607 - 25609	27001 - 27006	28114	30430 - 30462
15841 - 15850	21810	24155	25628	27030 - 27036	28118	30540 - 30545
15922	21825	24301	25645	27048 - 27049	28122	31075 - 31087
15935	22100 - 22226	24320 - 24331	25670	27052 - 27054	28130	31205 - 31230
19260 - 19272	22318 - 22328	24340 - 24346	25676	27065 -27080	28171	31300
19302 - 19318	22532 - 22900	24360 - 24470	25685	27087 - 27091	28202	31360 - 31420
19357 - 19369	23000 - 23020	24498	25695 - 25830	27097 - 27170	28210	31580
20100	23035 - 23040	24515 - 24516	25905 - 25915	27176 - 27181	28238	31584 - 31595
20150	23077 - 23100	24545 - 24546	25922 - 25924	27187	28250 - 28260	31601
20692	23105	24575	25929	27202	28262 - 28264	31611
20696 - 20902	23107 - 23125	24579	26185	27226 - 27228	28289	31750 - 31786
20922 -20924	23145	24586 - 24587	26255 - 26262	27236	28292 - 28306	31805
20937 - 20938	23150 - 23156	24615	26352	27244 - 27245	28308	32035 - 32200
20955 - 20973	23172 - 23174	24635	26357 - 26358	27248	28320 - 28322	32215 - 32320
20975	23182 -23222	24665 - 24666	26372 - 26392	27253 - 27254	28360	32402
21034	23332	24685 - 24931	26420	27258 - 27259	28415 - 28420	32440 - 32540
21044 - 21045	23395 - 23412	24940	26434	27267 - 27269	28445 - 28446	32650 - 32940
21047	23485 - 23491	25085	26474	27280 - 27299	28555	32998
21049	23515	25107	26479	27303 - 27306	28585	33020 - 33141
21060	23530 - 23532	25119	26483 - 26485	27310	28615	33243
21121 - 21180	23550 - 23552	25126	26492 - 26494	27325 - 27326	28705 - 28740	33250 - 33266
21182 - 21206	23585	25135 - 25145	26497 - 26499	27329	28760 - 28800	33261 - 33266
21209	23615 - 23616	25151 - 25170	26502	27331 - 27335	29804	33300 - 33417
21240 - 21247	23630	25215	26517 - 26518	27345 - 27365	29820 - 29828	33422 - 33502
21255 - 21275	23660	25250 - 25251	26530 - 26531	27380 - 27390	29834 - 29837	33504 - 33961
21339	23670	25263 - 25265	26541	27392 - 27415	29843 - 29845	33970
21343 - 21344	23680	25300 - 25335	26546	27418 - 27424	29847	33973
21347 - 21348	23800 - 23920	25350 - 25426	26550 - 26565	27427 - 27435	29851 - 29863	33975 - 34451
21360 -21395	23929	25431 - 25444	26568 - 26590	27438 - 27472	29884 - 29885	34501 - 34826
21401 - 21408	24006	25446 - 25449	26596	27479	29887 - 29892	34833 - 35206

CLAIMS – SPECIFIC POLICIES

* Assistant Surgeon Reimbursement (continued)

Assistant surgeon fees **ARE ALLOWABLE** on the following procedures and do **NOT REQUIRE** prior authorization when utilizing a Sante contracted assistant surgeon:

35211 - 35390
35450 - 35459
35480 - 35485
35491
35500
35501 - 35539
35548 - 35681
35685 - 35870
35876 - 35907
36261
36460
36818 - 36821
36825 - 36834
36838
37145 - 37181
37207 - 37208
37216
37600 - 37606
37615 - 37618
37660
37788
38100 - 38129
38204
38207 - 38215
38308 - 38382
38530 - 38542
38555 - 38780
39000 - 39220
39499 - 39599
40701 - 40702
40799
40840
40843 - 40844
41120 - 41155
42120

42200 - 42260
42299
42410 - 42440
42507 - 42508
42510
42699
42725
42810 - 42815
42844 - 42845
42890 - 42894
42950 - 42955
42961
42971 - 42972
43020 - 43135
43279 - 43415
43425
43496
43500 - 43520
43605 - 43659
43770 - 43888
44005 - 44055
44110 - 44130
44137 - 44310
44314 - 44322
44345 - 44346
44602 - 44721
44800 - 44900
44950 - 44979
45110 45136
45160 - 45170
45395 - 45499
45540 - 45825
46705
46710 - 46751
46760 - 46762

47010
47015 - 47381
47400 - 47480
47550
47562 - 47620
47700
47711 - 47900
48000 - 48100
48105 - 48155
48500 - 48510
48520 - 49020
49040
49062
49203 - 49220
49255 - 49329
49425
49435 - 49436
49491 - 49900
49905
50010
50045 - 50075
50081 - 50135
50205 - 50380
50400 - 50549
50562
50593 - 50660
50700 - 50949
51020
51040 - 51060
51080
51500 - 51597
51800 - 51992
53085
53210 - 53215
53230 - 53235

53400 - 53415
53425 - 53449
53500
53505 - 53515
54110 - 54135
54205
54250 - 54390
54405 - 54430
54440
54522 - 54560
54650
54680 - 54690
54699
55150
55400
55520
55535
55550 - 55559
55650
55706 - 55845
55862 - 55866
56620 - 56700
56800 - 56810
57106 - 57130
57200 - 57335
57423 - 57425
57530 - 57556
57720
58140 - 58294
58345
58356 - 58554
58560
58570 - 58662
58672 - 58770
58805 - 58822

58825 - 58960
58974 - 58976
59074 - 59121
59136 - 59151
59350
59514
59525
59620
59866 - 59870
59898 - 59899
60200 - 60281
60500 - 60699
61140
61154 - 61156
61250 - 61315
61320 - 61322
61330 - 61516
61518 - 61524
61531 - 61576
61582 - 61592
61596 - 61619
61630 - 61708
61711
61850 - 61880
62005 - 62147
62161 - 62164
62180
62192
62200
62220 - 62223
62230
62256 - 62258
62351
63001 - 63308
63655

63685
63700 - 63744
64580
64704 - 64716
64722
64732
64736 - 64742
64746 - 64772
64786
64792
64802 - 64818
64835 - 64840
64857 - 64911
65105 - 65114
65260 - 65265
65710 - 65756
65770
65781
65900
66165 - 66220
67027
67036 - 67043
67107 - 67108
67112 - 67113
67121
67255
67399
67413 - 67414
67420 - 67450
67570 - 67599
67973 - 67974
68720 - 68750
69155
69209
69320
69530

69550 - 69554
69605
69670
69711
69725 - 69745
69802 - 69805
69820 - 69840
69915
69950 - 69970

Prior authorization is **REQUIRED** to utilize an assistant surgeon for procedures **NOT** on the above list. Determination for authorization will be based on the surgeon’s documented complexity of the individual case.

CLAIMS – SPECIFIC POLICIES
* Third Party Liability

A Santé Physician may not refuse to see an HMO patient who may have a motor vehicle accident (MVA), or other Third Party Liability (TPL) injury (excluding workers' compensation). Additionally:

º The physician should always follow Santé policies and procedures (authorizations, referrals, plan providers) to ensure coverage if the TPL denies coverage.

º At no time should an HMO patient be billed full charges, and only when appropriate should a patient be billed a copay.

This policy is in line with contractual, legal and regulatory requirements.

Fee For Service PCPs & Specialists
Capitation Pool Specialists

Physicians who are paid fee for service for some or all services rendered to a Santé HMO patient have the following options:

■ Physician may bill TPL only

- Physician may get more reimbursement from the TPL carrier than from Santé
- If TPL denies coverage, Santé must be billed, not the patient. Include the TPL denial letter to avoid untimely filing denial by Santé.

■ Physician may bill Santé only, supplying Santé with TPL information and indicating *TPL NOT BILLED* on claim form

- Physician will be reimbursed by Santé. No additional money will be paid to physician if Santé collects from TPL carrier.

Capitation
PCPs & Cap Contract Specialists

Physicians who are paid by capitation for some or all services rendered to a Santé HMO patient have the following options:

■ Physician may bill TPL only

- Physician may get more reimbursement from the TPL carrier than from Santé
- If TPL denies coverage, Santé must be billed, not the patient. Include the TPL denial letter to avoid untimely filing denial by Santé.

■ Physician may bill Santé only, supplying Santé with TPL information and indicating *TPL NOT BILLED* on claim form

- Physician will be reimbursed by Santé through capitation

Capitated PCPs and Cap Contract Specialists may keep both Santé capitation and TPL payment.

Note regarding the HCFA 1500 form:

- Use field #19 when indicating **TPL NOT BILLED** as well as TPL carrier name, address and phone. (See sample HCFA 1500 form.)

CLAIMS – SPECIFIC POLICIES
* Workers' Compensation

Effective January 1, 2005, many changes were made to reform workers' compensation. The premise of this policy is to provide some general workers' compensation guidelines.

GENERAL GUIDELINES:

Physicians <u>Contracted</u> with SP's Workers' Compensation Panel:

Santé Physicians who have signed a contract addendum to be on SP's Workers' Compensation panel are <u>only</u> contracted to provide services to the following Networks:

- Community Care Network
- Fortified Provider Network
- Health Net
- Humana ChoiceCare
- Interplan
- Private Healthcare Systems

Claims/Utilization related questions or issues should be directed to the health plan carriers.

Physicians <u>Not Contracted</u> with SP's Workers' Compensation Panel:

Santé Physicians who have not signed a contract addendum to be part of SP's Workers' Compensation panel are free to decide to treat or not treat an injured worker. It is also permissible to refer the patient back to the employer for direction.

Please note: As a result of new reform legislation, in addition to a Workers Compensation HMO, called a Health Care Organization (HCO), an employer group may utilize a newly authorized private Medical Provider Network (MPN). In both of these cases, only a panel provider may provide treatment, unless other arrangements have been made with the workers compensation carrier.

It is also important to note that there will still be patients not covered by an HCO or MPN. You may wish to contact the patient's employer to verify your eligibility to receive payment for services, prior to rendering non-emergent treatment.

Disclaimer: Santé is not delegated to handle workers compensation claims. Any related questions or issues should be directed to the workers compensation carriers or the human resources specialist at the insurer's employer group.

CLAIMS – SPECIFIC POLICIES
* Direct Billing of Specific Blue Cross Services

Blue Cross CaliforniaCare has specific services that are billed directly to Blue Cross. The specific services are as follows:

Mammogram	77055, 77056, 77057 G0202, G0204, G0206
Immune Globulin	90281-90399
Vaccines, Toxoids	90476-90749
Antigen	95165
Injectables/Meds	J0120-J7199
Injectables/Meds	J7310-J7320
Injectables/Meds	J7500-J8999
Chemo Drugs	J9000-J9999
Injectables/Meds	Q0136-Q0181
Injectables/Meds	Q0187
Injectables/Meds	Q2001-Q2022
Injectables/Meds	Q9920-Q9940
Injectables/Meds	S0009-S0157

These claims must indicate authorization number *54321* in box 23 of the HCFA 1500 form. Submit claims to:

Anthem Blue Cross
Attn: CaliforniaCare Claims
P.O. BOX 60007
Los Angeles, CA 90060-0007

Note: All other services not listed are billed to Santé's Claims Department.

CLAIMS – SPECIFIC POLICIES
* Blue Cross-Specialty Pharmacy: Select Injectables & Self Injectables

Select Injectables & Self Injectables

Effective September 1, 2007, the procedure for the purchase and reimbursement of select high cost injectables and self-injectables has changed.

Injectables administered in the office and self-injectables that are listed on the following ***HMO Specialty Pharmacy Management Program list*** must be ordered through **CuraScript** on a **patient specific basis.** CuraScript will deliver the patient specific order to your office or patient's home. You will no longer have to carry the cost of these injectables – payment will only be made to CuraScript.

Ordering Workflow

Ordering specialty medications through CuraScript is designed to be quick, easy and convenient.

Step 1: Request Prior authorization from Santé as you normally would
(Only if this is an Injectable that requires prior auth – Please see list on the back of the prior-authorization form.)

Step 2: CuraScript can be reached at the numbers listed below. Care advocates are available to take calls Monday through Friday, from 5 a.m. to 7 p.m. Pacific Time. After hour calls will be routed to the appropriate on-call staff.

- Phone: 1-800-870-6419
- Fax: 1-800-824-2642
- Client Advocacy Phone: 1-888-662-0944 (dedicated unit for provider inquiries)
- For speech and hearing impaired assistance (TDD/TTY): 1-800-221-9615
- For the High Touch Team: 1-866-468-5787

Step 3: CuraScript will verify patient eligibility.

Step 4: The prescription is filled and medications are delivered promptly to the specified location.

Please feel free to contact Santé's Utilization Management Department for any questions you may have at (559) 228-5430.

(Continued)

Anthem.
Health. Join In.

Medical Provider-Administered Specialty Drug List

The following list reflects medications designated as specialty drugs. These specialty drugs may be covered under the medical benefit, **and if covered, must be obtained through CuraScript, the Express Scripts Specialty Pharmacy.** Whether the drug is to be given in the provider's office, by a home infusion provider, or in the member's home, the specialty drug must be obtained from CuraScript.

HCPS Code	Sample Trade Name	Generic (Chemical) Name(s)
J1035	Humira[1,3]	adalimumab
J0180	Fabrazyme[1]	agalsidase beta
J0205	Ceredase[1]	alglucerase
J0215	Amevive[1]	alefacept
J0220	Myozyme	algucosidase alfa
J0725	Novarel/Profasi/Pregnyl[3]	human chorionic gonadotropin (HCG)
J0800	Acthar HP	corticotrophin (ACTH)
J1438	Enbrel[1,3]	etanercept
J1595	Copaxone[1,3]	glatiramer actate
J1785	Cerezyme[1]	imiglucerase
J1825	Avonex[1,3]	interferon beta-1a, 33 mcg
J1830	Betaseron[1,3]	interferon beta-1b
J1931	Aldurazyme[1]	laronidase
J2170	Increlex[1,3]	mecasermin
J2357	Xolair[1,3]	omalizumab
J2597	DDAVP[3]	desmopressin acetate
J2940	Protropin[1,3]	somatrem
J2941	Genotropin/Humatrope/Saizen[1,3]	somatropin
J3110	Forteo[1,3]	teriparatide
J3355	Bravelle[3]	urofollitropin
J3490	Kineret[1,3]	anakinra
J3490	Cetrotide[3]	cetroelix acetate
J3490	Rebetron[1,3]	interferon alfa-2b + ribavirin capsules
J3490	Luveris[3]	lutropin alfa
J7187	Humate P[1,2]	von willebrand factor complex
J7189	NovoSeven[1,2]	factor viia
J7190	Factor VIII[1,2]	factor viii (human)
J7191	Factor VIII[1,2]	factor viii (porcine)
J7192	Factor VIII[1,2]	factor viii (recombinant)
J7193	Factor IX[1,2]	factor ix (non-recombinant)
J7194	Bebulin VH/Proplex T[1,2]	factor ix (complex)
J7195	Factor IX[1,2]	factor ix (recombinant)
J7198	Feiba VH[1,2]	anti-inhibitor coagulant complex
J7321	Hyalgan/Supartz[1]	hyaluronic acid derivatives
J7322	Synvisc[1]	hyaluronic acid derivatives
J7323	Euflexxa[1]	hyaluronic acid derivatives
J7324	Orthovisc[1]	hyaluronic acid derivatives
J7639	Pulmozyme[3]	dornase alpha inhalation solution
J9212	Infergen[1,3]	interferon alfacon-1
J9213	Roferon-A[1,3]	interferon alfa-2a
J9214	Intron-A[1,3]	interferon alfa-2b
J9215	Alferon-N[1,3]	interferon alfa-n3

This list of drugs is not a guarantee of coverage; please refer to your benefit booklet for specific coverage information. The list is sorted by HCPCS code. The most common brand name(s) and its corresponding generic (chemical) name are listed. This list is subject to change. Please visit www.anthem.com/ca for updates. CuraScript is able to provide other specialty drugs that are not listed and not part of this program. For additional information on other specialty drugs, please visit curascript.com.

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

Anthem. Health. Join In.

Medical Provider-Administered Specialty Drug List

The following list reflects medications designated as specialty drugs. These specialty drugs may be covered under the medical benefit, **and if covered, must be obtained through CuraScript, the Express Scripts Specialty Pharmacy.** Whether the drug is to be given in the provider's office, by a home infusion provider, or in the member's home, the specialty drug must be obtained from CuraScript.

HCPS Code	Sample Trade Name	Generic (Chemical) Name(s)
Q0515	Geref[3]	sermorelin acetate
Q3025	Avonex[1,3]	interferon beta-1a, 11 mcg
Q3026	Rebif[1,3]	interferon beta-1a, SubQ
S0017	Amicar	aminocaproic acid
S0122	Repronex/Menopur[3]	menotropins
S0126	Gonal-F[3]	follitropin alfa
S0128	Follistim-AQ[3]	follitropin beta
S0132	Antagon[3]	ganirelix acetate
S0145	Pegasys[1,3]	peginterferon alfa-2a
S0146	PEG-Intron[1,3]	peginterferon alfa-2b
S0162	Raptiva[1,3]	efalizumab

[1]Prior authorization (pre-service medical review) and approval by Anthem Blue Cross Specialty Medical Management (SPMM) may be required for PPO members. Please visit www.anthem.com/ca (providers) for detailed information and to download forms.

[2]Hemophilia factors dispensed and managed by 340B provider(s) do not need to be obtained through CuraScript.

[3]These specialty drugs may be covered under the outpatient prescription drug benefit, and if covered, are also required to be obtained through CuraScript. When benefits are provided for specialty drugs under the plan's medical benefits, they will not be provided under the prescription benefits, if included. Conversely, if benefits are provided for specialty drugs under the prescription drug benefits, if included, they will not be provided under the plan's medical benefits.

This list of drugs is not a guarantee of coverage; please refer to your benefit booklet for specific coverage information. The list is sorted by HCPCS code. The most common brand name(s) and its corresponding generic (chemical) name are listed. This list is subject to change. Please visit www.anthem.com/ca for updates. CuraScript is able to provide other specialty drugs that are not listed and not part of this program. For additional information on other specialty drugs, please visit curascript.com.

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Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

CLAIMS – SPECIFIC POLICIES
* Direct Billing of Specific Blue Shield Injectables

This policy applies to high cost injectables, chemotherapeutics and adjunctives

Effective September 1, 2007, high cost injectables (listed below), chemotherapeutics and adjunctives will be reimbursed directly by Blue Shield.

High cost injectables will continue to require prior authorization from Santé's Utilization Management Department.

Chemotherapy and adjunctive therapy do not require prior authorization.

Submit Claims Directly to Blue Shield:

Blue Shield Claims Department
P.O. Box 272550
Chico, CA 95927-2550

HIGH COST INJECTABLES

Code	**Code Description**	**Label Name**	**Generic Name**	**Type of Drug**	
90378	Respiratory syncytial virus immune globulin, human, for IM, 50 mg	Synagis	Immune globulin, Rho (IV)	Immune globulin, RSV (IM)	
J0180	INJECTION, AGALSIDASE BETA, 1MG	Fabrazyme		Enzyme therapy	
J0215	INJECTION, ALEFACEPT, 0.5 MG	AMEVIVE	Alefacept	Psoriatic	
J1745	INJECTION INFLIXIMAB, 10 MG	REMICADE 100MG VIAL	Infliximab injection	Crohn's, RA	
J1931	INJECTION, LARONIDASE, 0.1MG	Aldurazyme		Enzyme therapy	
J2357	INJECTION, OMALIZUMAB, 5 MG	XOLAIR	Omalizumab	Monoclonal antibody (Asthma)	
J2505	INJECTION, PEGFILGRASTIM, 6 MG	NEULASTA	Pegfilgrastim	Blood	
J9010	ALEMTUZUMAB, 10 MG	Campath	Alemtuzumab injection	Chemotherapeutic	
J9035	INJECTION, BEVACIZUMAB, 10MG	Avastin	Bevacizumab	Chemotherapeutic	
J9041	INJECTION, BORTEZOMIB, 0.1 MG	VELCADE	Bortezomib	Chemotherapeutic	
J9055	INJECTION, CETUXIMAB, 10MG	ERBITUX			
J9263	INJECTION, OXALIPLATIN, 0.5 MG	ELOXATIN	oxaliplatin	Chemotherapeutic	
J9300	GEMTUZUMAB OZOGAMICIN, 5MG	MYLOTARG 5MG VIAL	Gemtuzumab ozogamicin	Chemotherapeutic	
J9305	INJECTION, PEMETREXED, 10MG	ALIMTA			
J9310	RITUXIMAB, 100 MG	RITUXAN 10MG/ML VIAL	Rituximab cancer treatment	Chemotherapeutic	
J9355	TRASTUZUMAB, 10 MG	HERCEPTIN 440MG VIAL	Trastuzumab	Chemotherapeutic	
J9999	NOT OTHERWISE CLASSIFIED, ANTINEOPLASTIC DRUGS	Chemotherapy drugs	Chemotherapy drug	Chemotherapeutic	**Bexxar, Zevalin only (J9999)**

J1458	INJECTION, GALSULFASE, 1 MG	Naglazyme	Galsulfase	Enzyme Therapy
J9025	INJECTION, AZACITIDINE,100MG	Vidaza	Azacitidine	Chemotherapeutic
J9264	INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES, 1 MG	Abraxane		
J9027	INJECTION, CLOFARABINE, 1 MG	Clolar		
J0129	ABATACEPT	Orencia	Abatacept	
Q4079	Natalizumab, injection per 1mg	Tysabri		
J9027	INJECTION, CLOFARABINE, 1 MG	Clolar		
S0147	Alglucosidase alfa, per 20mg	Myozyme		
J9261	Nelarabine per 50mg	Arranon		

CLAIMS – SPECIFIC POLICIES

* Health Net- Specialty Pharmacy: Self Administered Injectables

This applies to Commercial HMO & Healthy Families/Kids

Self-Administered Injectables

Effective April 15, 2007, the procedure for the purchase of self-administered injectables has changed. Health Net has contracted with two specialty pharmacy providers to provide self-administered injectables to your Health Net and Healthy Families/Kids HMO patients.

Ordering Workflow

Step 1: Request prior authorization from Santé as you normally would.

Step 2: Once you receive the authorization from Santé, fill out the following "Health Net Injectable Form" and write Santé's authorization number on the form (this will serve as your written prescription).

Step 3: Fax both Health Net's form and Santé's prior authorization to Health Net's Pharmacy Department at (818) 676-8086.

Step 4: Health Net will then contact either Curascript or Caremark specialty pharmacy to arrange to have the self-administered Injectable sent to the patient. The patient will receive a call from the specialty pharmacy within 24 hours of receiving the request to arrange for delivery.

Should you have any questions regarding this process you may contact Santé's Utilization Management Department at (559) 228-5430.

Pharmacy Prior Authorization Form – Injectable

Fax Completed Form to (818) 676-8086

PA forms and guidelines are available on the provider portal of www.healthnet.com

If the fax number provided is not a dedicated machine to you or your staff, please check this box ▯

Patient Name	Date of Birth
Patient's ID Number	Patient's Phone Number ( )

Physician's Name and Specialty	Medical Group Name
Physician's Address	City, State, Zip Code
Physician's Phone Number ( )	Physician's Fax Number ( )
Are you the patient's primary care physician? ▯ YES ▯ NO	Has the patient provided an authorized referral? ▯ YES ▯ NO
Utilization Management Authorization # (attach copy)	Date Medication Needed
Patient's Primary Care Physician Name	Primary Care Physician's Fax Number ( )
Diagnosis:	**ICD-9 code:**

Medication	**Strength**	**Directions**	**Qty/mth**	**Duration**
Administered: ▯ Doctor's Office ▯ In Dialysis Center ▯ By Patient ▯ Other: ________________				

Medications Tried and Failed:				
Date	Name, Strength & Formulation	Dose	Duration	Outcome
Date	Name, Strength & Formulation	Dose	Duration	Outcome

Lab values or other supporting information to establish medical necessity.

I certify that the above information is correct to the best of my knowledge and that I will be supervising the treatment accordingly. I further authorize administration of supplies (syringes, needles) related to therapy.

Physician's Signature ________________________________ Date ____________________

This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination, or copying of this message, or any attachment, is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by return E-mail and delete this message along with any attachments, from your computer. Thank you.

Rev. 1/07 Injectable Request Form

CLAIMS – SPECIFIC POLICIES
* Health Net- Direct Billing of Therapeutic & Self Injectables

Effective April 1, 2009, Health Net will be financially responsible for paying claims for all in-office/outpatient therapeutic injectables.

Effective April 1, 2009, Health Net will be financially responsible for paying claims for all patient administered injectables.

Bill Claims to:

Health Net
P.O. Box 14702
Lexington, KY 40512

SANTÉ PHYSICIANS

CLAIMS – SPECIFIC POLICIES
* Vaccine Billing Matrix

Since January 1, 2001, California Law requires Health Plans to assume the financial responsibility for newly approved or recommended childhood immunizations. Some health plans require providers to bill them directly for reimbursement, while other health plans compensate medical groups, such as Santé, to process the reimbursement on their behalf.

Likewise, as new adult vaccines are developed, the health plans may choose to assume the financial risk for these vaccines.

Health Plan reimbursement rates vary by plan for vaccines that are health plan financial risk, and also may vary over time. Santé Physicians is not responsible for variations or changes in Health Plan reimbursement rates for vaccines. For information on the most current vaccine reimbursement rates paid by the health plans, you must contact the plans directly.

The billing matrix below provides you with an "at-a-glance" outline of where to file vaccination claims for reimbursement.

CHILDHOOD VACCINES

Code	Vaccine	Health Plans → Blue Cross	Blue Shield	UnitedHealthcare Signature Value	Health Net	Cigna	Aetna	Community Care Health
90649	Gardasil (Female) (Follows ACIP Recommendations)	Blue Cross	Blue Shield	UnitedHealthcare SV	Health Net	Cigna	Aetna	CCH
90649	Gardasil (Male) (Follows ACIP Recommendations)	Blue Cross	Blue Shield	UnitedHealthcare SV	Health Net	Cigna	Aetna	CCH
90650	Cervarix	Blue Cross	Blue Shield	UnitedHealthcare SV	Health Net	Cigna	Aetna	CCH
90655	Influenza Virus (age 6-35 months)	Blue Cross	Blue Shield	UnitedHealthcare SV	Santé	Santé	Aetna	Santé
90656	Influenza Virus (ages 3-18)	Blue Cross	Blue Shield	UnitedHealthcare SV	Santé	Santé	Aetna	Santé
90657	Influenza Virus (age 6-35 months)	Blue Cross	Santé	UnitedHealthcare SV	Santé	Santé	Aetna	Santé
90658	Influenza Virus (ages 3-older)	Blue Cross	Blue Shield	UnitedHealthcare SV	Santé	Santé	Aetna	Santé
90669	Prevnar (PCV 7)	Blue Cross	Blue Shield	Santé	Santé	Santé	Aetna	CCH
90670	PCV 13	Blue Cross	Blue Shield	UnitedHealthcare SV	Santé	Cigna	Aetna	CCH
90672	Flumist	Blue Cross	Blue Shield	UnitedHealthcare SV	Santé	Santé	Santé	Santé
90672	FluMist Quadrivalent	Blue Cross	Blue Shield	UnitedHealthcare SV	Santé	Santé	Santé	Santé
90680	Rotateq	Blue Cross	Blue Shield	UnitedHealthcare SV	Health Net	Cigna	Aetna	CCH
90681	Rotarix	Blue Cross	Blue Shield	UnitedHealthcare SV	Health Net	Cigna	Aetna	CCH
90685	Fluzone Quadrivalent (ages 6-35 mo)	Blue Cross	Blue Shield	Santé	Santé	Santé	Santé	Santé

90686	EZ Flu Shot Kit; Fluzone Quadrivalent; Fluarix Quadrivalent	Blue Cross	Blue Shield	UnitedHealthcare SV	Santé	Santé	Santé	Santé
90688	Flulaval Quadrivalent	Blue Cross	Blue Shield	UnitedHealthcare SV	Santé	Santé	Aetna	Santé
90696	Kinrix	Blue Cross	Santé	Santé	Santé	Santé	Santé	Santé
90698	Pentacel	Blue Cross	Santé	Santé	Santé	Santé	Santé	Santé
90710	Proquad (MMR Varicella)	Blue Cross	Santé	Santé	Santé	Santé	Santé	Santé
90715	Tdap Boostrix/Adecel)	Blue Cross	Blue Shield	UnitedHealthcare SV	Health Net	Santé	Aetna	CCH
90716	Varicella 1st dose	Blue Cross	Blue Shield	Santé	Health Net	Santé	Santé	CCH
90716	Varicella 2nd dose	Blue Cross	Blue Shield	UnitedHealthcare SV	Health Net	Santé	Aetna	CCH
90734	Menactra	Blue Cross	Blue Shield	UnitedHealthcare SV	Health Net	Santé	Santé	CCH
	ChildhoodVaccines prior to 2001* *Vaccines developed and recommended by the ACIP prior to 2001	Blue Cross	Santé	Santé	Santé	Santé	Santé	Santé

ADULT VACCINES

Code	Health Plans → / Vaccine ↓	Blue Cross	Blue Shield	Blue Shield 65 Plus	Brand New Day	United Healthcare Signature Value	AARP Medicare Complete	UHC Medicare Solutions: Group Retiree	Health Net	Health Net Seniority Plus	Cigna	Aetna	Aetna M/A	Anthem Medicare	Community Care Health
90649	Gardasil (Female) (Follows ACIP Recommendations**)**	Blue Cross	Blue Shield	N/A	BND	United Healthcare SV	N/A	N/A	Health Net	N/A	Cigna	Aetna		Anthem Medicare	CCH
90649	Gardasil (Male) (Follows ACIP Recommendations**)**	Blue Cross	Blue Shield	N/A	BND	United Healthcare SV	N/A	N/A	Health Net	N/A	Cigna	Aetna		Anthem Medicare	CCH
90650	Cervarix	Blue Cross	Blue Shield	N/A	BND	United Healthcare SV	N/A	N/A	Health Net	N/A	Cigna	Aetna		N/A	CCH
90651	HPV Vaccine	Blue Cross	Blue Shield	N/A	BND	United Healthcare SV	Santé	Santé	Health Net	Santé	Cigna	Aetna		Santé	CCH
90658	Influenza Virus 18yrs & over	Blue Cross	Santé	Santé	BND	Santé	Santé	Santé	Santé	Santé	Santé	Santé		Santé	Santé
90670	Prevnar 13	Blue Cross	Santé	Santé	BND	Santé	Santé	Santé	Santé	Santé	Santé	Aetna		Santé	CCH
90686	EZ Flu Shot Kit; Fluzone Quadrivalent; Fluarix Quadrivalent	Blue Cross	Santé	Santé	BND	Santé	Santé	Santé	Santé	Santé	Santé	Santé		Santé	Santé
90688	FluLaval	Blue Cross	Santé	Santé	BND	Santé	Santé	Santé	Santé	Santé	Santé	Santé		Santé	Santé
90715	Boostrix/Adacel	Blue Cross	Blue Shield	Santé	BND	Santé	Santé	Santé	Santé	Santé	Santé	Santé		Santé	CCH
90716	Varivax Dose 1 & 2	Blue Cross	Blue Shield	Santé	BND	Santé	Santé	Santé	Santé	Santé	Santé	Santé		Santé	CCH
90734	Menactra	Blue Cross	Blue Shield	Santé	BND	Santé	Santé	Santé	Santé	Santé	Santé	Santé		Santé	CCH
90736	Zostavax	Blue Cross	Blue Shield	Part D Benefit	BND	Santé	Part D Benefit	Part D Benefit	Health Net	Part D Benefit	Santé	Aetna		Anthem Medicare	CCH
	All other Adult Vaccines	Blue Cross	Santé	Santé	BND	Santé	Santé	Santé	Santé	Santé	Santé	Santé		Santé	Santé

Health Plan Billing Address	Contact Numbers
Aetna P.O. Box 14089 Lexington, KY 40512-4089	(800) 624-0756
Aetna Medicare P.O. Box 981106 El Paso, TX 79998-1106	(888) 268-9800
Blue Cross CaliforniaCare P.O. Box 60007 Los Angeles, CA 90060-0007	(888) 657-9677
Blue Shield P.O. Box 272550 Chico, CA 95927-2550	(800) 444-1409
Brand New Day Attention: Claims Department P.O. Box 794 Park Ridge, IL 60068	(866) 255-4795
Cigna Healthcare P.O. Box 5048 Visalia, CA 93278	(800) 244-6224
Community Care Health (CCH) P.O. Box 45020 Fresno, CA 93718	(855) 343-2247
Health Net P.O. Box 14702 Lexington, KY 40512	(800) 641-7761
UnitedHealthcare (Formerly PacifiCare) Attn: Commercial Claims P.O. Box 30968 Salt Lake City, UT 84130-0968	(800) 624-8822

IPA Billing Address	Contact Number
Santé P.O. Box 1507 Fresno, CA 93716-1507	(559) 228-5410

WEBSITE
* Access and Information

Internet access enables physician practices to streamline operational processes.

As an Office Manager or staff member of a Santé Physician, access to the following time saving features is available:

- √ Authorization Status
- √ Eligibility Inquiry
- √ Specialty Roster for Referrals
- √ Administrative Manual On-Line
- √ Quality Improvement Manual On-Line
- √ Downloadable Forms and Tools
- √ Education Calendar for Office Managers/Staff
- √ Pay for Performance Tool Kit
- √ The Latest HIPAA Information

As a Santé Physician, access to all of the above features *plus* the following tools and information is available:

- √ Disease Registry Reports for Primary Care Physicians
- √ Cost and Utilization Reports
- √ SP Education Events
- √ SP Annual Report & Financials

To Receive a Password

Step 1: Go to **www.santehealth.net**
Step 2: Click on the “Sign-up” link
Step 3: Choose Provider Access or Office Manager/Staff Access
Step 4: Print Form, Fill Out, and Fax to (559) 224-2046

Note: Regarding Office Manager/Staff Access - If the request is for a group practice, provide the group name and list the name and license number of each physician in the group. This will enable Santé to provide access to all files related to the group practice. The lead physician in the group practice must authorize the request.