2018 Blue Dot Changes to the *Blue Cross Complete Provider Manual* and related documents

The most recent changes are shown with a Blue Dot.

Change Description

- The following updates are made to the *Blue Cross Complete Provider Manual* **(January 2018)**:

- **Section 2 - Systems of Managed Care** (p. 6): Added language that informs providers that CHAMPS enrollment is required
- **Section 2 - Systems of Managed Care** (p. 8): Added language that informs providers that same day transportation is available
- **Section 5 - Standards and Ratings** (p. 26): Added non-urgent symptomatic care, speciality care, acute speciality care and dental health access standards

- The following updates are made to the *Blue Cross Complete Provider Manual* **(February 2018)**:

- **Section 4 - Managing the Quality of Care** (p. 20): Changed “chief medical director” to “medical director”
- **Section 4 - Managing the Quality of Care** (p. 21): Steps 1,2,4,6, 7 and 8 in the peer review process were revised for clarity.
- **Section 4 - Managing the Quality of Care** (p. 22): Added to step 2 “in writing within 30 calendar days of the date of the letter”
- **Section 4 - Managing the Quality of Care** (p. 22): Removed from step 3 “For cases reviewed by committees, the committee makes a decision and forwards it to the designated Blue Cross Complete chief medical officer within 30 calendar days.”
- **Section 4 - Managing the Quality of Care** (p. 22): Added to step 3 “If the case is forwarded to a committee, the committee reviews the case and request that a...”
- **Section 4 - Managing the Quality of Care** (p. 22): Added to step 4 “The letter also notifies the practitioner that he or she has the right to ...”
- **Section 4 - Managing the Quality of Care** (p. 22): Removed from step 5 “Blue Cross Complete monitors compliance with the performance improvement plan. Noncompliance or unsatisfactory compliance may result in termination”
- **Section 4 - Managing the Quality of Care** (p. 23): Added “If deemed appropriate, the disciplinary steps may be completed on an expedited basis...”
- **Section 4 - Managing the Quality of Care** (p. 23): *Medical boards and data bank must be notified* revised for clarity. Note: Action resulting in restriction or regulation of clinical practice for a period greater than 30 days has been changed to 15 days.
- **Section 4 - Managing the Quality of Care** (p. 23): *Additional information about termination* revised for clarity.
- **Section 4 - Managing the Quality of Care** (p. 23): Added “An effective and consistent practitioner appeal process is available for when ...”

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Change Description

- The following updates are made to the *Blue Cross Complete Provider Manual* **(February 2018) continued**:

- **Section 4 Managing the Quality of Care** (p. 23): Added a definition of *administrative issues*
- **Section 4 Managing the Quality of Care** (p. 23): Added a definition of *quality of care issues*
- **Section 4 Managing the Quality of Care** (p. 24): Removed from section 2 of *Level 1 appeal process* "The committee's decision is communicated to the appealing practitioner by certified letter within 60 days of the decision"
- **Section 4 Managing the Quality of Care** (p. 24): Added additional clarity for administrative and quality of care issues to section 2 of *Level 1 appeal process.*
- **Section 4 Managing the Quality of Care** (p. 25): *Level 2 appeal process* step 3 changed 30 days to 14 calendar days and added "For non-emergent terminations, a written decision is provided within 30 days".
- **Section 10 Managing Utilization** (p. 55): Added "...within three business days. Please follow the peer to peer request process as indicated in section 10B" to *What to do if the stay is denied*
- **Section 10 Managing Utilization** (p. 58): Removed from *Peer-to-Peer Request for Denied Services* section "If a request for inpatient or outpatient authorization is denied, the ordering or treating provider can request a Peer-to-Peer discussion with the Blue Cross Complete chief medical officer who issued the adverse determination. A Peer-to-Peer request will be accepted up to three business days from the date of the original denial.
- **Section 10 Managing Utilization** (p. 58): Added "A Peer to Peer request will be accepted up to three business days from the date of the original denial.
- **Section 10 Managing Utilization** (p. 58): Changed timeframes from 60 to 30 and added "calendar days" to standard appeal timeframe.
- **Section 10 Managing Utilization** (p. 58): Changed timeframes from 60 to 10 and added "calendar days" to expedited appeal timeframe.
- **Section 10 Managing Utilization** (p. 59): Removed "Claims appeal" information from this section
- **Section 13 Managing Utilization** (p. 55): Removed *Guidelines for appealing a denied claim* from this section
- **Section 14 Provider appeals** (p. 89): Added Provider appeals section to the provider manual