

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.

Co-payments

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

Co-payments – Unpaid

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

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

If a patient fails to pay an outstanding co-payment, the physician office may:

- Send the patient to collections
- Reschedule any non-urgent appointment when co-payment 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 co-payment not paid at the time of service.

CUSTOMER SERVICE

*** Overview (Continued)**

Co-payments – Missed Appointment

A co-payment may not be collected for a missed appointment.

Co-payments – 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 co-payment.

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

* Overview (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

A secure log-in is required to obtain this information. Visit www.santephysicians.com and click on "New User." Fill out the submission form and the Portal Support team will provide access within a 24 hr. period.

HMO Eligibility Verification and Co-payments

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 co-payment amount. However, the provider office should verify the member's PCP assignment, eligibility and co-payment 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 |
| • Wellcare (Health Net) | www.wellcare.com |
| • United Healthcare Signature Value HMO (Formerly PacifiCare Commercial HMO) | www.uhcwest.com |
| • AARP Medicare Complete (Formerly Secure Horizons) | www.uhcmedicareolutions.com/health-plans/medicare-advantage-plans |
| • United Healthcare Medicare Solutions: GroupRetiree (Formerly Secure Horizons) | www.uhcmedicareolutions.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 co-payment 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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)

LANGUAGE ASSISTANCE PROGRAM

(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	800-541-6652
	In Person.....	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.

LANGUAGE ASSISTANCE PROGRAM

(Continued)

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
Cigna	Culturalandlinguisticsunit@cigna.com
Wellcare (Health Net)	800-522-0088
United Healthcare	800-730-7270 – Spanish
(Formerly PacifiCare)	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

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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*

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http://www.hablamosjuntos.org/signage/symbols/default_using_symbols.asp#bpw*

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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):	
<input type="checkbox"/> This request is urgent. Note: Providers must forward request from member to Blue Shield within one business day.	
<input type="checkbox"/> 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)	
<input type="checkbox"/> Yes <input type="checkbox"/> 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 #:
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Provider Address:

Patient Name:	Date of Birth:
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Member ID Number:	Claim Number (if known):
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Service "From – To" Date:	Original Claim Amount Billed:	Original Submission Date:
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INDICATE REASON FOR INQUIRY AND PROVIDE A DETAILED DESCRIPTION:

<p>Inquiry Type:</p> <p><input type="checkbox"/> Resubmission of "contested" claim with missing information. (documentation attached)</p> <p><input type="checkbox"/> Status of Claim (i.e., no receipt of payment)</p> <p><input type="checkbox"/> Clarification on calculation of payment</p> <p><input type="checkbox"/> Assistance in determining member responsibility</p>

_____	_____	_____
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

<u>CPT Code</u>	<u>Fee Schedule</u>
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

* 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.

*** 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 balance 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 to 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	42200 - 42260	47010	53400 - 53415	58825 - 58960	63685	69550 - 69554
35450 - 35459	42299	47015 - 47381	53425 - 53449	58974 - 58976	63700 - 63744	69605
35480 - 35485	42410 - 42440	47400 - 47480	53500	59074 - 59121	64580	69670
35491	42507 - 42508	47550	53505 - 53515	59136 - 59151	64704 - 64716	69711
35500	42510	47562 - 47620	54110 - 54135	59350	64722	69725 - 69745
35501 - 35539	42699	47700	54205	59514	64732	69802 - 69805
35548 - 35681	42725	47711 - 47900	54250 - 54390	59525	64736 - 64742	69820 - 69840
35685 - 35870	42810 - 42815	48000 - 48100	54405 - 54430	59620	64746 - 64772	69915
35876 - 35907	42844 - 42845	48105 - 48155	54440	59866 - 59870	64786	69950 - 69970
36261	42890 - 42894	48500 - 48510	54522 - 54560	59898 - 59899	64792	
36460	42950 - 42955	48520 - 49020	54650	60200 - 60281	64802 - 64818	
36818 - 36821	42961	49040	54680 - 54690	60500 - 60699	64835 - 64840	
36825 - 36834	42971 - 42972	49062	54699	61140	64857 - 64911	
36838	43020 - 43135	49203 - 49220	55150	61154 - 61156	65105 - 65114	
37145 - 37181	43279 - 43415	49255 - 49329	55400	61250 - 61315	65260 - 65265	
37207 - 37208	43425	49425	55520	61320 - 61322	65710 - 65756	
37216	43496	49435 - 49436	55535	61330 - 61516	65770	
37600 - 37606	43500 - 43520	49491 - 49900	55550 - 55559	61518 - 61524	65781	
37615 - 37618	43605 - 43659	49905	55650	61531 - 61576	65900	
37660	43770 - 43888	50010	55706 - 55845	61582 - 61592	66165 - 66220	
37788	44005 - 44055	50045 - 50075	55862 - 55866	61596 - 61619	67027	
38100 - 38129	44110 - 44130	50081 - 50135	56620 - 56700	61630 - 61708	67036 - 67043	
38204	44137 - 44310	50205 - 50380	56800 - 56810	61711	67107 - 67108	
38207 - 38215	44314 - 44322	50400 - 50549	57106 - 57130	61850 - 61880	67112 - 67113	
38308 - 38382	44345 - 44346	50562	57200 - 57335	62005 - 62147	67121	
38530 - 38542	44602 - 44721	50593 - 50660	57423 - 57425	62161 - 62164	67255	
38555 - 38780	44800 - 44900	50700 - 50949	57530 - 57556	62180	67399	
39000 - 39220	44950 - 44979	51020	57720	62192	67413 - 67414	
39499 - 39599	45110 45136	51040 - 51060	58140 - 58294	62200	67420 - 67450	
40701 - 40702	45160 - 45170	51080	58345	62220 - 62223	67570 - 67599	
40799	45395 - 45499	51500 - 51597	58356 - 58554	62230	67973 - 67974	
40840	45540 - 45825	51800 - 51992	58560	62256 - 62258	68720 - 68750	
40843 - 40844	46705	53085	58570 - 58662	62351	69155	
					69209	
41120 - 41155	46710 - 46751	53210 - 53215	58672 - 58770	63001 - 63308	69320	
42120	46760 - 46762	53230 - 53235	58805 - 58822	63655	69530	

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:

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

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

same options as those listed above and including the aforementioned

Capitated PCPs and Capitated 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 Contracted with SP's Workers' Compensation Panel:

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

- Fortified Provider Network
- Wellcare (Health Net)
- Humana ChoiceCare
- Interplan
- Private Healthcare Systems

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

Physicians Not Contracted 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)

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.

HCPCS 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	alglucosidase 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 acetate
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/Humatropo/Saizen ^{1,3}	somatropin
J3110	Forteo ^{1,3}	teriparatide
J3355	Bravelle ³	urofolitropin
J3490	Kineret ^{1,3}	anakinra
J3490	Cetrotide ³	cetorelix 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.

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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.



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.

HCPCS 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

¹Prior 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.

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

³These 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

*** Wellcare (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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has the patient provided an authorized referral? <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> Doctor's Office <input type="checkbox"/> In Dialysis Center <input type="checkbox"/> By Patient <input type="checkbox"/> Other: _____				

Medications Tried and Failed:				
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.

CLAIMS – SPECIFIC POLICIES

*** Wellcare (Health Net)- Direct Billing of Therapeutic & Self Injectables**

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

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

Bill Claims to:

Wellcare
P.O. Box 14702
Lexington, KY 40512

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

Health Plans →

Anthem Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Cigna	Aetna
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WHERE TO MAIL CLAIMS

↓ ↓ ↓ ↓ ↓

Code ↓
Vaccine ↓

Childhood Vaccines

Code	Vaccine	Anthem Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Cigna	Aetna
90619	Meningococcal conjugate vaccine	Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Santé	Aetna
90649	Gardasil (Female) (Follows ACIP Recommendations)	Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Cigna	Aetna
90649	Gardasil (Male) (Follows ACIP Recommendations)	Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Cigna	Aetna
90650	Cervarix	Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Cigna	Aetna
90655	Influenza Virus (age 6-35 months)	Blue Cross	Blue Shield	UnitedHealthcare	Santé	Santé	Aetna
90656	Influenza Virus (ages 3-18)	Blue Cross	Blue Shield	UnitedHealthcare	Santé	Santé	Aetna
90657	Influenza Virus (age 6-35 months)	Blue Cross	Santé	UnitedHealthcare	Santé	Santé	Aetna
90669	Prevnar (PCV 7)	Blue Cross	Blue Shield	Santé	Santé	Santé	Aetna
90670	PCV 13	Blue Cross	Blue Shield	UnitedHealthcare	Santé	Cigna	Aetna
90672	Flumist	Blue Cross	Blue Shield	UnitedHealthcare	Santé	Santé	Santé
90672	FluMist Quadrivalent	Blue Cross	Blue Shield	UnitedHealthcare	Santé	Santé	Santé
90674	Flucevax Quadrivalent (age 6 mo-17 years)	Blue Cross	Blue Shield	UnitedHealthcare	Santé	Santé	Santé

90680	Rotateq	Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Cigna	Aetna
90681	Rotarix	Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Cigna	Aetna
90685	Fluzone Quadrivalent	Blue Cross	Blue Shield	UnitedHealthcare	Santé	Santé	Santé
90686	EZ Flu Shot Kit; Fluzone Quadrivalent; Fluarix Quadrivalent	Blue Cross	Blue Shield	UnitedHealthcare	Santé	Santé	Santé
90688	Flulaval Quadrivalent	Blue Cross	Blue Shield	UnitedHealthcare	Santé	Santé	Santé
90696	Kinrix	Blue Cross	Santé	Santé	Santé	Santé	Santé
90698	Pentacel	Blue Cross	Santé	Santé	Santé	Santé	Santé
90700	Dtap	Blue Cross	Santé	Santé	Santé	Santé	Santé
90707	MMR	Blue Cross	Santé	Santé	Santé	Santé	Santé
90710	Proquad (MMR Varicella)	Blue Cross	Santé	Santé	Santé	Santé	Santé
90713	Polio	Blue Cross	Santé	Santé	Santé	Santé	Santé
90715	Tdap Boostrix/Adecel)	Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Santé	Aetna
90716	Varicella 1 st dose	Blue Cross	Blue Shield	Santé	Health Net	Santé	Santé
90716	Varicella 2 nd dose	Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Santé	Aetna
90734	Menactra	Blue Cross	Blue Shield	UnitedHealthcare	Health Net	Santé	Santé
90744	HepB	Blue Cross	Santé	Santé	Santé	Santé	Santé
	Childhood Vaccines prior to 2001	Blue Cross	Santé	Santé	Santé	Santé	Santé

ADULT VACCINES

Health Plans →

Alignment	Blue Cross	Blue Shield	Blue Shield Medicare	UnitedHealthcare	UnitedHealthcare Medicare	Health Net	Health Net Medicare	Cigna	Aetna	Aetna Medicare	Brand New Day
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Code ↓
Vaccine ↓

		Adult Vaccines												
90619	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use	Santé	Blue Cross	Blue Shield	Santé	Santé	Santé	Santé	Santé	Santé	Santé	Santé	Santé	BND
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use	Santé	Blue Cross	Blue Shield	Santé	Santé	Santé	Santé	Santé	Santé	Santé	Santé	Santé	BND
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use	Santé	Blue Cross	Blue Shield	Santé	Santé	Santé	Santé	Santé	Santé	Santé	Santé	Santé	BND
90649	Gardasil (Female) (Follows ACIP Recommendations)	Santé	Blue Cross	Blue Shield	N/A	United Healthcare	N/A	Health Net	N/A	Santé	Aetna	N/A	N/A	
90649	Gardasil (Male) (Follows ACIP Recommendations)	Santé	Blue Cross	Blue Shield	N/A	UnitedHealthcare	N/A	Health Net	N/A	Santé	Aetna	N/A	N/A	
90650	Cervarix	Santé	Blue Cross	Blue Shield	N/A	United Healthcare	N/A	Health Net	N/A	Santé	Aetna	N/A	N/A	
90651	HPV	Santé	Blue Cross	Blue Shield	N/A	United Healthcare	N/A	Health Net	N/A	Santé	Aetna	N/A	N/A	

OPERATIONS

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

Wellcare (Health Net)
P.O. Box 14702
Lexington, KY 40512

(800) 641-7761

United Healthcare (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

Chemotherapy vs Infusion Therapy

Infusion Therapy and Non Cancer Chemotherapy					Chemotherapy			
Plan	Drug	Remicade	Infusion Therapy Administration (Facility- UB Claim)	Infusion Therapy Administration (Professional Claim- CMS Form)	Chemotherapy Drugs	Chemotherapy Adjunct Drugs	Chemotherapy Administration (Facility- UB Claim)	Chemotherapy Administration (Professional Claim- CMS Form)
Commercial								
Aetna	Aetna	Aetna	Aetna	Aetna	Aetna	Aetna	Santé	Santé
Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Santé	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Santé
Blue Shield	Santé	Blue Shield	Blue Shield	Santé	Blue Shield	Blue Shield	Blue Shield	Santé
Cigna	Santé	Santé	Santé	Santé	Santé	Santé	Santé	Santé
Health Net	Health Net	Health Net	Health Net	Health Net	Health Net	Health Net	Health Net	Santé
UnitedHealthCare	UnitedHealthCare	UnitedHealthCare	UnitedHealthCare	UnitedHealthCare	Santé	Santé	Santé	Santé
Medicare								
Aetna	Aetna	Aetna	Aetna	Aetna	Aetna	Aetna	Santé	Santé
Alignment	Santé	Santé	Santé	Santé	Santé	Santé	Santé	Santé
Anthem Blue Cross	Sante	Santé	Santé	Santé	Anthem Blue Cross	Anthem Blue Cross		
Blue Shield	Santé	Santé	Santé	Santé	Santé	Santé	Santé	Santé
Brand New Day	Brand New Day	Brand New Day	Brand New Day	Santé	Brand New Day	Brand New Day	Santé	Santé
CVHP	CVHP Facility Sante Professional	CVHP Facility Sante Professional	CVHP	Santé	CVHP Facility Sante Professional	CVHP Facility Sante Professional	CVHP	Sante
Health Net	Santé	Santé	Health Net	Health Net POS 22 Santé POS 11	Health Net	Health Net	Health Net	Santé
UnitedHealthCare	UnitedHealthCare	UnitedHealthCare	UnitedHealthCare	UnitedHealthCare	Santé	Santé	Santé	Santé
Medi-Cal								
Anthem Blue Cross	Santé	Santé	Anthem Blue Cross	Santé	Santé	Santé	Anthem Blue Cross	Santé
Health Net Cal Viva	Santé	Santé	Health Net	Santé	Health Net	Health Net	Santé	Santé
Plan	Therapeutic Injection	Therapeutic Injection Provided in Urgent Care setting	Self Injectables	Implantable Medication				
Commercial								
Aetna	Aetna	Aetna	Aetna	Aetna				
Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Blue Cross				
Blue Shield	Santé	Santé	Blue Shield	Santé				
Cigna	Santé	Santé	Santé	Santé				
Health Net	Health Net	Santé	Health Net	Health Net				
UnitedHealthCare	Santé	Santé	Santé	Santé				
Medicare								
Aetna	Aetna	Aetna	Aetna	Aetna				
Alignment	Santé	Santé	Santé	Santé				
Anthem Blue Cross	Sante	Sante	Sante	Anthem Blue Cross				
Blue Shield	Santé	Santé	Blue Shield	Santé				
Brand New Day	Santé	Santé	Brand New Day	Brand New Day				
CVHP	Santé	Santé	Santé	Santé				
Health Net	Santé	Santé	Santé	Santé				
UnitedHealthCare	Santé	Santé	Santé	Santé				
Medi-Cal								
Anthem Blue Cross	Santé	Santé	Anthem Blue Cross	Santé				
Health Net Cal Viva	Santé	Santé	Health Net	Health Net				

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

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 Access

- Step 1: Go to www.santephysicians.com
- Step 2: Click on "New User"
- Step 3: Fill out form and once complete, click "submit"
- Step 4: The Portal Support Team will then grant access within a 24-hour period. For portal support, please email portalsupport@santehealth.net