Provider Manual
BCBSNC Plans

CEC
community eye care
Vision Benefits Made Simple
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Community Eye Care (CEC) is the eye care affiliate of Blue Cross and Blue Shield of North Carolina (BCBSNC). CEC serves as the routine vision network for the health plan’s commercial and ASO products. In addition, CEC administers routine vision services and serves as the medical/surgical eye care network for the BCBSNC Medicare Advantage program (Blue Medicare).
Routine Vision Network for BCBSNC Commercial

The Community Eye Care (CEC) network serves as the exclusive eye care network for routine vision services and vision hardware provided to commercial members of Blue Cross and Blue Shield of North Carolina (BCBSNC), effective May 1, 2016. Only those optometric, ophthalmologic and multi-specialty providers who participate on the CEC panel are considered in-network routine vision providers for BCBSNC’s commercially underwritten and administrative services only (ASO) products.

Note that routine vision claims for BCBSNC commercial members are filed with BCBSNC, but they are processed under the terms of each provider’s participation agreement with CEC.
Routine Vision Codes

Routine Eye Exams
When billing for routine eye examinations in BCBSNC commercial members, the following procedure codes should be used:

- 92002
- 92012
- 92004
- 92014
- S0620
- S0621

The codes listed above generate identical reimbursement. They are designated as routine, and they should be used exclusively for routine eye examinations. They should not be used to bill for medical eye examinations.

Refraction is an integral part of each routine examination. Accordingly, refractions cannot be unbundled from routine eye examinations (i.e., cannot be billed in conjunction with routine eye exams as distinct services).

Evaluation and management codes (99-thousand series) should be used exclusively for medical eye care. They should not be used to bill for routine eye examinations.

Eyewear
Eyewear codes include:

- Frame: V2020, V2025, V2035
- Single Vision Lens: V2100 – V2118
- Bifocal Lens: V2200 – V2220
- Trifocal Lens: V2300 – V2320
Routine Vision Claims

For commercial BCBSNC members, routine vision claims are filed with BCBSNC. Information on how to submit these claims is provided on the next page (page 6).

Note that for Medicare Advantage (Blue Medicare) members, routine vision claims are filed with CEC, while non-routine (medical/surgical) claims are filed with Blue Medicare.

The following table summarizes the guidelines for filing claims:

<table>
<thead>
<tr>
<th>Routine Vision</th>
<th>Product</th>
<th>Routine Vision Network</th>
<th>Routine Vision Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BCBSNC Commercial (HMO, POS* and PPO)</td>
<td>CEC**</td>
<td>BCBSNC</td>
</tr>
<tr>
<td></td>
<td>BCBSNC Medicare Advantage (Blue MedicareSM)</td>
<td>CEC</td>
<td>CEC</td>
</tr>
<tr>
<td></td>
<td>CEC Vision Plans</td>
<td>CEC</td>
<td>CEC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical / Surgical</th>
<th>Product</th>
<th>Medical / Surgical Network</th>
<th>Medical / Surgical Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BCBSNC Commercial (HMO, POS* and PPO)</td>
<td>BCBSNC</td>
<td>BCBSNC</td>
</tr>
<tr>
<td></td>
<td>BCBSNC Medicare Advantage (Blue MedicareSM)</td>
<td>CEC</td>
<td>BCBSNC</td>
</tr>
</tbody>
</table>

*Varying participation status for POS product lines, such as Blue Local and Blue Value.
**FEP and other government employer groups use different routine vision carriers.
How to File Routine Vision Claims

With respect to routine vision services and vision hardware provided to BCBSNC commercial members, all claims should be submitted to BCBSNC:

**Main Mailing Address**
BCBSNC
P.O. BOX 35
Durham, NC 27702

**Online**
www.bcbsnc.com

**Phone**
800-214-4844

*Note: Blue e can be utilized to obtain and submit claims, verify member eligibility, check the status of a claim, and obtain or confirm prior authority.*
Routine Fee Schedule

The CEC fee schedule for BCBSNC routine eye exams and vision hardware is as follows:

Routine Exams: $61, inclusive of any co-payment

Hardware: The fee schedule for pediatric hardware benefits under ACA plans is summarized in the following table:

<table>
<thead>
<tr>
<th>Retail Cost</th>
<th>Lenses and/or Contact Lenses</th>
<th>Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>up to $100</td>
<td>Plan Pays 100%</td>
<td>Plan Pays 100%</td>
</tr>
<tr>
<td>$100 to $300</td>
<td>$50 Co-Pay Plan Pays Balance</td>
<td>$50 Co-Pay Plan Pays Balance</td>
</tr>
<tr>
<td>Over $300</td>
<td>Member Pays 50% Plan Pays 50%</td>
<td>Member Pays 50% Plan Pays 50%</td>
</tr>
</tbody>
</table>

For non-pediatric hardware (frames, lenses and contact lenses), fees are based on the following hierarchy:

a. 100% of provider's reasonable billed charges
b. 100% of NC Medicare DMEPOS fee schedule
c. 100% of OptumInsight fees
d. 103% of invoice cost
Routine Vision Examination

A routine vision examination should include:

- History
- Visual acuity at distance
- Near acuity, when indicated
- Refraction and/or autorefraction
- Visual field screening by confrontation
- Pupillary reflexes, including a swinging flashlight test
- Ocular alignment (primary gaze) and range of eye movement
- External examination
- Biomicroscopy
- Tonometry
- Retinal examination (direct and/or indirect ophthalmoscope, with dilation of the pupils when indicated)
- Diagnosis and treatment plan, including prescribing of corrective lenses when indicated

Examination of Diabetic Patients

Exams performed in patients with Type 1 or Type 2 diabetes must include evaluation of the retina (ophthalmoscopy) and evaluation of the anterior segment of the eye (biomicroscopy). This requirement applies to routine screening exams and to medical eye exams.
BLUE MEDICARE
Eligibility and Authorizations for Providers

Routine Vision Services

You have two options for obtaining authorizations and information regarding Blue Medicare member eligibility.

OPTION 1: cecvision.com

1. Visit our website and click on the tab labeled Providers. Then click on Login.
2. Log in with your Tax Identification Number and the Provider’s First and Last Name. (You must log in as the doctor providing services).
3. Click on the Authorizations tab. Next, click Add and select your practice location. (Must be the practice address for which services were authorized).
4. Then enter the Member Identification Number and click Go.
5. Next, select the name of the patient in the Choose Member field by using the drop-down arrow.
6. To save the authorization, enter the date of service, choose the applicable services, and click on Obtain Authorization.

OPTION 2: 888-254-4290

Press 1 for providers. Press 1 again for routine vision eligibility and authorizations.

Please have the following information and materials available when obtaining authorizations and information about member eligibility:

- Patient’s name
- Member Identification Number and date of birth
- Provider's first and last name
Routine Vision Claims

There are two types of diagnoses associated with eye examinations performed for Blue Medicare members. Claims for these two types of diagnoses are filed differently.

1. Examinations with a routine diagnosis are filed with, processed by, and paid by Community Eye Care (CEC).
2. Examinations with a medical diagnosis are filed with Blue Medicare. Information on how to file these claims begins on page 11 of this manual.

Routine Vision Exams

The following procedure codes will identify an eye examination as routine: 92012, 92002, 92004, 92014, S0620, S0621. To be valid, the exam code must be supported by a routine diagnosis code. Note that providers are required to use ICD-10 diagnosis codes when submitting claims to CEC. Routine vision exams are reimbursed at $52, inclusive of any co-payment.

Eyewear

Some Blue Medicare members have vision plans that include a provision for eyewear. For those that do, providers must obtain an authorization from Community Eye Care for the eyewear.

Eyewear codes include:

- Frame: V2020, V2025, V2035
- Single Vision Lens: V2100 – V2118
- Bifocal Lens: V2200 – V2220
- Trifocal Lens: V2300 – V2320
How to File Routine Vision Claims

You have four options for submitting routine vision claims (routine diagnosis) for Blue Medicare members. These claims are processed and paid by CEC.

**OPTION 1: cecvision.com**
1. Visit our website and click on the tab labeled Providers. Then click Login.
2. Log in with your Tax Identification Number and the Provider's First and Last Name. (You must log in as the doctor providing services).
3. Click on the Claims tab. Next, click on Add.
4. Then enter the Authorization Number and click Go.
5. Fill in the claim information and click on File Claim. You are done!

**OPTION 2: E-Claims**
CEC accepts claims via electronic 837 file format

**OPTION 3: Submit CMS/HCFA 1500 paper forms to:**
Community Eye Care / Blue Medicare Routine
2359 Perimeter Pointe Parkway, Suite 150
Charlotte, NC 28208

**OPTION 4: Fax**
CMS/HCFA 1500 paper forms can be faxed to 1-704-413-7098
Blue Medicare Medical and Surgical Services

Medical Eye Exams for Blue Medicare Members
All claims associated with a *medical diagnosis code* should be submitted directly to Blue Medicare.

<table>
<thead>
<tr>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBSNC/BLUE MEDICARE</td>
</tr>
<tr>
<td>PO Box 17509</td>
</tr>
<tr>
<td>Winston-Salem, NC 27116-7509</td>
</tr>
<tr>
<td>USPS, FEDEX, UPS, &amp; 4TH CLASS</td>
</tr>
</tbody>
</table>

Phone: 1-888-296-9790

Emergencies
If, in your professional opinion, the patient’s medical or surgical eye problem represents an emergency, you should provide the necessary care on an emergent basis. Eligibility may be confirmed thereafter. If an emergent surgical procedure is performed, retroactive approval should be obtained within 72 hours.
Medical / Surgical Claims

The following information pertains to submission of claims for medical and/or surgical eye care services provided to Blue Medicare members. The most recent Blue Book™ Provider Manual - Blue Medicare HMO™ and Blue Medicare PPO™ Supplemental Guide, as well as additional policy and resource information, can be found on the BCBSNC website at http://www.bcbsnc.com/content/providers/blue-medicare-providers/index.htm.

Blue Medicare normally pays claims within 30 days of the date of claims receipt. However, improper submission can create delays in timely processing and reimbursement of claims and can cause claims to be returned for revision.

Claims for medical and/or surgical eye care services must be submitted electronically through Blue e℠ or on an 837 file. Claims may also be submitted on standard CMS / HCFA 1500 claim forms.

Each claim should clearly indicate the following patient information:

- Patient’s name
- Date of birth
- Member identification number
- Coordination of benefits information
- Date of service
- Place of service
- All applicable ICD-10 diagnosis codes
- Charges for each service
- Quantity / units
- Signature of the ophthalmologist or optometrist performing the service

Covered Medical / Surgical Services

The following services are reimbursable to participating providers:

- Office-based medical eye care services
- Diagnostic tests performed within the practitioner's office
- Pre-authorized surgical procedures

*Refer to the fee schedule on page 18 for a list of codes accepted for covered services

Glasses After Cataract Surgery

Claims for glasses prescribed after cataract surgery should be filed with Blue Medicare and supported by a medical diagnosis code.
Refraction Policy

Unlike standard (i.e., traditional) Medicare, Blue Medicare provides coverage for routine eye examinations. This supplemental coverage comes with certain billing requirements. In particular, a provider cannot bill either the member or CEC for a refraction performed on or for a Blue Medicare member. Please note the following:

- Refractions are part and parcel of routine eye exams for Blue Medicare members.
- Blue Medicare members should not be billed for a refraction performed incidental to a medical eye exam. Refraction is part of a routine eye exam, which is a covered service under Blue Medicare.

Non-Covered Services

Blue Medicare does not reimburse eye care providers for the following services:

- Facility Cost
- Corneal Transplant Tissue
- Prosthetic Intra-Ocular Lenses (V2630-V2632)
- Prosthetic Eyes (92393; V2623-V2629)
- Professional Vision Screening by PCP (<18 years old) (92499)
- Diagnostic Tests Performed at Laboratories of Diagnostic Centers
- Experimental Treatments
- Cosmetic Surgery
- Contact Lens Fitting
- Contact Lens Evaluation
Referral Guidelines

Ophthalmologists and Optometrists can participate in providing medical / surgical eye care to Blue Medicare members as allowed by the full scope of practice of each profession.

Blue Medicare is a Direct Access benefit for all ophthalmic medical and surgical services. Medical and surgical services provided by optometrists and ophthalmologists do not require referral or authorization from the member’s Primary Care Physician (PCP).

Use of Participating Providers
When referring a Blue Medicare member to another eye care provider, you should make the referral to a doctor who is on the Blue Medicare panel of participating providers. The only exception to this would be for services that are not available from any participating provider in the network.
Prior Approval for Surgery

*Blepharoplasty* requires pre-authorization (i.e., prior approval) by calling Blue Medicare at one of the numbers listed below. When calling to request authorization, you should have available all of the clinical data that is needed for a decision regarding approval under the Blue Medicare utilization management program.

1-888-296-9790 for PPO and HMO support  
1-888-298-7552 for PDP support  
1-800-672-6584, Option 1 for Blue Medicare Supplement support

**Procedure:** Blepharoplasty

**CPT#:** 15820, 15821, 15822, 15823

**Clinical Data:**

1. Patient’s symptoms (e.g., visual impairment due to drooping of eyelids, lower eyelids touching bifocals, skin irritation, etc.)

2. Results of a visual field test – automated or Goldmann – with specific reference to the limit of the superior visual field (in degrees)

3. Is there a history of dry eyes? If so, is the condition mild, moderate, or severe?

*If the procedure is being proposed for a problem other than constriction of the upper visual field, provide the following data:*

4. Presence of entropion (inturning of the eyelid)

5. Chronic inflammation of the surface of the eye, the eyelid margins (blepharitis), or the skin around the eye (dermatitis)

6. Use of an ocular prosthesis (“glass eye”)

7. History of Grave’s disease (thyroid eye disease). If present, inquire as to whether any further orbital or muscle surgery is planned.

8. Recurrent headaches related to sustained contraction of the forehead muscles (compensatory “brow hiking”)
Verifying Medical Claim Status

You can inquire about the status of a claim in one of the following ways:

1. Blue e\textsuperscript{SM} enables users to verify the status of Blue Medicare claims. Providers without Blue e\textsuperscript{SM} access can call the BCBSNC Provider Line at 1-888-296-9790.

To learn more about Blue e\textsuperscript{SM}, visit Electronic Commerce on the web at [http://www.bcbsnc.com/content/providers/blue-medicare-providers/index.htm](http://www.bcbsnc.com/content/providers/blue-medicare-providers/index.htm)

2. Complete a provider claim inquiry form and fax it to the BCBSNC Customer Service Department, 1-336-774-5400.

** Please allow 45 days after a claims submission date before initiating an inquiry or submitting a previously filed claim.**

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**Detailed Rejected Section**

<table>
<thead>
<tr>
<th>1. Original claim number</th>
<th>2. BCBSNC claim number</th>
<th>3. Error type</th>
<th>4. Error description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invoice number or patient account number as provided by the submitter</td>
<td>Blue Medicare claim number</td>
<td>Relates to the summary section under rejected status and can be one of three possibilities: map, load or denied</td>
<td>Reason why claim was rejected</td>
</tr>
</tbody>
</table>
Blue Medicare Med/Surg Codes and Fee Structure

Under the Blue Medicare program, eye care providers submit all medical claims directly to Blue Medicare. Blue Medicare processes and pays these claims based on the following:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract Surgery</td>
<td>$701</td>
</tr>
<tr>
<td>Medical Eye Exams &amp; Consultations</td>
<td>97% of current Medicare rates</td>
</tr>
<tr>
<td>Medical eye exam &amp; consultation codes:</td>
<td></td>
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<tr>
<td></td>
<td>99201-99205</td>
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<tr>
<td></td>
<td>99211-99215</td>
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<td></td>
<td>99221-99223</td>
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<td></td>
<td>99241-99245</td>
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<tr>
<td></td>
<td>99251-99255</td>
</tr>
<tr>
<td>Vitreoretinal Surgery</td>
<td>100% of current Medicare rates</td>
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<tr>
<td>Vitreoretinal codes:</td>
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<td></td>
<td>67005</td>
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<td></td>
<td>67010</td>
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<td>67015</td>
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<td>67038</td>
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<tr>
<td>Retinal Laser Procedures</td>
<td>100% of current Medicare rates</td>
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<tr>
<td>Laser codes:</td>
<td></td>
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<td></td>
<td>67031</td>
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<td></td>
<td>67039</td>
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<td></td>
<td>67040</td>
</tr>
<tr>
<td>Office Medications</td>
<td>100% of current Medicare rates</td>
</tr>
<tr>
<td>Other Procedures</td>
<td>90% of current Medicare rates</td>
</tr>
</tbody>
</table>
Provider Sanction Process

I. Scope

The sanction process outlines the procedures and actions used by Community Eye Care to respond to a potential or actual problem with a Participating Provider. This section sets forth the sanction procedures for physicians and non-physicians who are CEC Participating Providers.

II. The Sanction Process

Sanctions are defined and instituted by the CEC Quality Improvement Committee. Recommendations for sanctions may be made to the Quality Improvement Committee by a health plan, by the CEC Medical Director, or by the CEC Management Committee.

III. Conduct For Which Sanctions May Be Imposed

Sanctions may be imposed for unacceptable quality of care, inappropriate utilization of services, or failure to fulfill the requirements of the Participating Provider Agreement.

A. Quality-of-Care Problems

1. Quality-of-care problems may be identified by members, providers, or through the process of administering the utilization management or quality improvement programs. Identified problems which are felt to have the potential to result in serious harm to members will be handled immediately by the CEC Medical Director.

2. If an inquiry confirms the existence of a quality of care issue, the findings will be communicated to the physician whose care was the subject of inquiry. The physician will have the right to request reconsideration of the decision or to appeal as described in the appeal process.
B. Inappropriate Utilization of Medical Services

Inappropriate utilization of medical services for which sanctions may be imposed includes, but is not limited to the following:

1. Inappropriate practice patterns, including, but not limited to, unnecessary admissions, failure to seek prior authorization in a timely manner, or repeated referrals to non-participating providers.

2. Failure to respond appropriately to reasonable requests from CEC or a health plan for information regarding patient management. Inappropriate responses include rudeness, denial of access to ordinary patient information necessary for medical management, and failure to respond to written requests for information.

3. Scheduling of procedures, diagnostic tests, or hospital admissions that are judged to be not medically necessary.

4. Performing outpatient surgical procedures on an inpatient basis without prior authorization or circumstances precluding prior authorization.

5. Identified patterns of over-utilization of ancillary services.

6. Under-utilization of services, manifesting as failure to provide preventive care, failure to make needed referrals, and/or higher than usual member dissatisfaction.

7. Questionable charges or billing practices.

C. Failure to Fulfill Provider Agreement Obligations

Sanctions may be imposed for failure to fulfill conditions and obligations specified in the CEC Participating Provider Agreement, including, but not limited to, the following:

1. The provider no longer satisfies the participation criteria specified in the Provider Agreement or has been unable to perform the obligations set forth in those criteria.

2. The provider made misrepresentations in his/her initial application or application for re-credentialing.

3. The provider has made misrepresentations to a health plan or to a member of a health plan regarding provision of services.

4. The provider has undertaken action or initiated communications with patients or health plan members (or prospective members) which would reasonably be calculated to undermine confidence in CEC or in health plans that contract with CEC.
5. The provider has incurred a mental or physical disability imparting his/her ability to provide high quality and appropriate health care services to members.

6. The provider has failed to cooperate with or adhere to reasonable guidelines incorporated in CEC’s utilization management and quality improvement programs.

IV. Types of Sanctions

Sanctions may include, but are not limited to, restriction of privileges, suspension of privileges, or termination of the CEC Participating Provider Agreement.

Sanctions are of two general types:

A. Standard Sanctions
A standard sanction is a sanction established by the Quality Improvement Committee to respond to a common violation of administrative policy, such as non-compliance with guidelines for pre-authorization of surgical procedures or unauthorized referral of members to non-participating providers. Standard sanctions may consist of remedial education and documentation in the credentialing file, but not restriction, suspension, or termination of privileges as a participating provider.

B. Non-Standard Sanctions
Non-standard sanctions are established by the Quality Improvement Committee to respond to some form of unacceptable practice by a provider. Examples of non-standard sanctions include documentation of the quality issue in the credentialing file, restriction of privileges, time-limited suspension from participating in the network, or termination of the Participating Provider Agreement.
V. Sanction Procedures

Standard Sanctions
When a standard sanction is imposed, the physician shall be given written notice of institution of the sanction and the reason therefore. The physician has the right to request reconsideration by the Quality Improvement Committee and may appear before the committee and/or present additional or clarifying information. After reconsideration, the committee’s decision is final.

Non-Standard Sanctions
All other sanctions are individual provider non-standard sanctions and are imposed by the Quality Improvement Committee after receiving a recommendation from the CEC Medical Director, the CEC Management Committee, or a health plan that contracts with CEC. Non-standard problems include, but are not limited to, substandard quality of care; persistent inappropriate utilization despite attempts at education and constructive remediation; misrepresentations related to claims; and violation of the terms and/or conditions of the CEC Participating Provider Agreement. When a non-standard sanction is imposed, the provider shall be given written notice of institution of the sanction and the reason(s) for the sanction. The physician has the right to request reconsideration by the Quality Improvement Committee and may appear before the committee and/or present additional or clarifying information. After reconsideration, the committee’s decision is final. Non-standard sanctions that could result in restriction or termination of participation in the CEC provider network are imposed only after implementation of established due process procedures (see below).

VI. Restriction, Suspension, or Termination of Privileges as a Participating Provider for Unacceptable Quality of Care

If the CEC Quality Improvement Committee is considering recommending restriction, suspension, or termination of privileges as a participating provider for reasons relating to quality of care, the provider shall be given notice, in writing, of the potential action and the reasons for the proposed sanctions.

Such notice shall advise the provider that he or she may attend the committee meeting at which his or her case will be considered and that he or she may be accompanied by counsel and may provide witnesses with information relevant to the matter.

At the committee meeting, the provider shall be advised of the concerns of the committee and be given an opportunity to respond to those concerns. After review of all relevant information, including information provided by the provider, the committee shall determine whether to recommend termination or any other sanctions. The provider will be informed in writing of the committee’s decision. Uncontested decisions to suspend or terminate a provider’s participation as a CEC network provider will be reported to each health plan with which CEC maintains a contractual relationship.
VII. Appeal Procedure

The provider may appeal a decision to restrict, suspend or terminate for reasons relating to quality of care by submitting written notice within thirty (30) days following receipt of notice of the action. Following receipt of the written appeal, the Quality Improvement Committee shall appoint an Appeals Committee consisting of at least three providers not previously involved in the sanction process, one of whom practices in the same specialty as the sanctioned provider. The provider shall have the right to appear before the Appeals Committee, to be represented by counsel, and to present relevant testimony or information. After consideration of all relevant available information, the Appeals Committee shall make a recommendation to the Quality Improvement Committee. If the recommendation of the Appeals Committee is that the sanction action should be upheld, the initial action of the Quality Improvement Committee shall become its final action. If the Appeals Committee recommends reconsideration, the Quality Improvement Committee shall reconsider its action (taking into account any recommendations or suggestions from the Appeals Committee) and take whatever action it determines is appropriate. The Quality Improvement Committee shall provide written notice to the provider within 10 days after making its final decision and within 60 days of receipt of the provider’s appeal notice. If the final decision involves suspension or termination of the provider’s participation as a CEC network provider, the decision will be reported to each health plan with which CEC maintains a contractual relationship.

VIII. Summary Suspension

If a quality or utilization problem of sufficient seriousness to cause potential harm or liability to a member is identified, the CEC Medical Director shall have the authority to summarily suspend a provider’s participation status or restrict his or her practice as a CEC Participating Provider. If such action is taken, written notice shall be sent to the provider within 10 days of the action taken.

Such written notice shall advise the provider of the action, give the reasons for the action, and advise the provider of the process for determining whether the CEC Participating Provider Agreement should be terminated and/or whether any other sanctions should be imposed. The matter shall be referred to the Quality Improvement Committee no later than 30 days following the summary suspension.