October 15, 2018

Subject: **Notification of January 2019 Updates to the Blue Shield *Hospital and Facility Guidelines***

Dear Provider:

We have revised our *Hospital and Facility Guidelines.* The changes listed on the following pages are effective January 1, 2019.

On that date, you can search and download the revised manual on Provider Connection at www.blueshieldca.com/provider in the *Provider Manuals* section under the *Guidelines & Resources* tab.

You may also request a CD version of the revised *Hospital and Facility Guidelines* be mailed to you, once it is published, by emailing providermanuals@blueshieldca.com.

The *Hospital and Facility Guidelines* is referenced in the agreement between Blue Shield of California (Blue Shield) and the hospitals and other facilities contracted with Blue Shield. If a conflict arises between the *Hospital and Facility Guidelines* and the agreement held by the hospital or other facility and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the January 2019 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Vice President, Provider Network Management
Blue Shield of California

UPDATES TO THE JANUARY 2019
HOSPITAL AND FACILITY GUIDELINES

Section 1: Introduction

ENROLLMENT AND ELIGIBILITY

Blue Shield Enrollment Responsibilities to Members on the Exchange

Updated *language in boldface type below:*

Under the Patient Protection and Affordable Care Act (PPACA) for Exchange-purchased individual insurance policies eligible for premium subsidies, when premiums/dues are not received from members, there will be a three-month (90-day) **delinquency** period. During this grace period, Blue Shield may not disenroll **delinquent** members **but may suspend claims payments unless and until member premiums are received in full.** See Section 4: Special Billing Situations for Blue Shield's responsibilities regarding unpaid premiums for Exchange members.

Retroactive Cancellation/Ineligible Member

Updated *language to indicate that this provision does not apply to BlueCard Host, Medicare Advantage, and the Federal Employee Program.*

MEMBER RIGHTS AND RESPONSIBILITIES

Updated *the Statement of Member Rights to align with Evidence of Coverage (EOC) language.*

Section 2: Hospital and Facility Responsibilities

QUALITY MANAGEMENT AND IMPROVEMENT

Added *a new section on reporting C-section rates and HACs as required by Covered California and CMS.*

Reporting Specified C-Section Rates

To comply with Covered California requirements, hospitals must report quarterly to the Maternal Data Center of the California Maternal Quality Care Collaborative the number of nulliparous women with a term, singleton baby in a vertex position ((NTSV) delivered by cesarean section.

- Numerator: uncomplicated c-sections MS-DRG 766
- Denominator: all born MS-DRGs 765, 766, 767, 768, 774, 775
- Exclusions: twins and higher ICD-10s O30091, O30109, O30099, O30041, O30090, O30009

Section 2: Hospital and Facility Responsibilities *(cont'd.)*

Reporting Hospital-Acquired Conditions to CMS

To comply with the Centers for Medicare & Medicaid Services (CMS) and Covered California requirements, hospitals must report to Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) quarterly rates of hospital-acquired conditions (HACs) specified below using CDC's reporting criteria (www.cdc.gov/nhsn/pdfs/validation/2018/pcsmanual_2018-508.pdf):

- Methicillin-resistant Staphylococcus aureus (MRSA)
- Catheter-associated Urinary Tract Infection (CAUTI)
- Central Line-associated Bloodstream Infection (CLABSI)
- Colorectal Surgical Site Infection (SSI Colon)
- Clostridium difficile Infection (CDI)

PROVIDER AVAILABILITY STANDARDS FOR COMMERCIAL PRODUCTS

Updated the Geographic Distribution table for the category of PCPs in boldface type below:

The standard is one PCP within 15 miles **or 30 minutes** of each member.

LANGUAGE ASSISTANCE FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY (LEP)

Blue Shield's threshold languages for 2019 are ***Spanish, Chinese – Traditional, and Vietnamese.***

Section 3: Medical Care Solutions

MEDICAL CARE SOLUTIONS PROGRAM OVERVIEW AND FUNCTIONS

Removed *pharmacists as part of the Blue Shield Medical Care Solutions professional staff and removed prior authorization of pharmaceuticals as a Medical Care Solutions function.*

Changed *the timeframe of which Blue Shield's Medical Care Solutions Department will contact the provider for urgent requests to inform them of the status of their request for care or services from 24 hours to 72 hours.*

ADMISSION AUTHORIZATION

Prior Authorization/Elective

Added *language in boldface type below:*

The physician or hospital must obtain authorization (when applicable) for Blue Shield member hospital admissions from the designated Medical Care Solutions team five days prior to an elective admission. **If prior authorization is not required, the physician or hospital must notify the Medical Care Solutions team at time of admission.**

Removed *the following language as it no longer applies:*

To expedite claims processing, if the hospital has received authorization from a delegated IPA/medical group, the hospital should contact Blue Shield Medical Care Solutions five days prior to an elective admission with the IPA/medical group authorization number and obtain a Blue Shield reference number for tracking purposes.

ORGAN AND BONE MARROW TRANSPLANTS

Updated *language in boldface/strikethrough type below:*

All transplant referrals must be to an **approved** ~~California~~ network transplant facility for benefits to be paid.

The following transplants are also eligible for coverage but are handled as routine inpatient services by the designated Medical Care Solutions Prior Authorization Department for all members:

- Cornea
- Kidney only
- Skin

No special centers are required as long as a Blue Shield of California contracted facility is used, and, for kidney transplants, the facility is Medicare-certified.

ADMISSION AND CONCURRENT INPATIENT REVIEW

Updated *language in boldface type below:*

Authorization for additional days beyond the authorized length of stay must be obtained from the designated Medical Care Solutions team one day prior to the end of the authorized length of stay. **Failure to request prior to rending services may result in non-coverage.** The facility is notified within 24 hours of the decision by telephone, fax, or in writing of the determination to continue the stay.

QUALITY OF CARE ASSESSMENT *has been changed to* QUALITY OF CARE REVIEWS

The entire section has been ***rewritten*** *as follows:*

Blue Shield has a comprehensive review system to address quality of care concerns. This process may be initiated by a member, member representative, internal staff, or network provider.

Potential quality issues are forwarded to Blue Shield's Quality Management Department for clinical review that may include an evaluation and peer review by professionals of similar types and degrees of experience. The Clinical Quality Review nurse collects clinical records and provider responses and compiles a care summary. The case may then be forwarded to a Blue Shield Medical Director for review and confirmation of any quality of care issues. When necessary, the case may also be reviewed by the Blue Shield Peer Review Committee. Based on the findings and case outcome, requests may be made to the hospital or involved providers for additional documentation or follow-up actions, such as a corrective action plan. Contracted providers are obligated to participate in quality of care reviews and provide requested documentation.

Additional follow-up actions may be taken depending on the severity of the issues. These actions may include a referral to the provider's file kept by the Blue Shield Credentialing Department, which may be utilized during routine credentialing or re-credentialing activities or referral to Blue Shield's Credentials Committee for further peer review and immediate credentialing consideration. Committee findings, actions, and recommendations are documented in detailed minutes. The minutes produced in these physician-based committee meetings are protected from discovery by the Health and Safety Code Section 1370 and the Evidence Code 1157. The Peer Review and Credentials Committee report aggregate findings to the Quality Management Committee.

Section 4: Billing and Payment

CLAIMS SUBMISSION

UB 04 Form Locators

Removed *references to Provider Identification Number (PIN) and replaced with National Provider Identifier (NPI) on claims form instructions. Blue Shield no longer uses the PIN.*

WHERE TO SUBMIT CLAIMS

Electronic Claims

Added *a link to the EDI Inquiry form on the provider portal at https://www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp.*

PROVIDER APPEALS AND DISPUTE RESOLUTION

Removed *references to the Internal Control Number (ICN) and replaced with the Blue Shield assigned claim number as the way to identify a claim.*

Removed *references to ClaimCheck as it has been replaced with Claims Xten.*

Section 5: Blue Shield Benefit Plans and Programs

MEDICARE PART D PRESCRIBER ENROLLMENT REQUIREMENT *has been changed to* MEDICARE PART D PRESCRIBER PRECLUSION LIST

The section below has been ***rewritten.*** *CMS has eliminated the Medicare Part D Prescriber Enrollment Requirement and replaced it with a Preclusion List.*

The Centers for Medicare & Medicaid Services (CMS) is eliminating the prescriber and provider enrollment requirement for Part C and Part D and instead is compiling a "Preclusion List" of prescribers, individuals, and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. CMS will make the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by, or associated with, prescriptions written by prescribers and providers on the list. Full enforcement of the Part C and D prescriber exclusion list requirement will begin on January 1, 2019.

Additionally, the added provisions require organizations offering Part D to cover a three-month provisional supply of the drug and provide beneficiaries with individualized written notice before denying a Part D claim or beneficiary request for reimbursement on the basis of a prescriber's being neither enrolled in an approved status nor validly opted out. The three-month provisional supply is intended to give the prescriber time to enroll in Medicare or opt-out and ensure beneficiary access to prescribed medication.

FEDERAL EMPLOYEE PROGRAM (FEP)

Precertification for Inpatient Hospital Admissions

Updated *language in boldface type below:*

Preferred providers are responsible for obtaining pre-certification for all inpatient admissions to preferred hospitals. Pre-certification requires notification prior to scheduled admissions or within two business days after an emergency admission, even if the member has been discharged from the hospital within those 2 days. The member will be subject to the $500 benefit reduction if admitted to a preferred hospital and pre-certification is not obtained. The member is ultimately responsible for ensuring that pre-certification has been completed. If the pre-certification is not obtained, the member's inpatient hospital benefit for covered services will be reduced by $500. (For specific rules, please refer to Section 3 the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure located at Fepblue.org). Pre-certification is not needed for a maternity admission for a routine delivery. If the baby stays after the mother is discharged, then the physician must contact Blue Shield for pre-certification of additional days for the baby. **The subscriber must add the baby to the plan before certification for services to be provided.**

Added *the following new section:*

Required Prior Authorization

Members must obtain prior approval for these services under both the Standard and Basic Option. Precertification is also required if the service or procedure requires an inpatient hospital admission. Contact Blue Shield at the prior authorization number at (800) 633-4581 before receiving these types of services. Find more information about the services below in the BCBSA Service Benefit Plan (SBP) Brochure at https://www.fepblue.org/benefit-plans/benefit-plans-brochures-and-forms.

FEDERAL EMPLOYEE PROGRAM (FEP) *(cont'd.)*

Prior Approval is required for:	Additional Information
Outpatient sleep studies performed outside the home	Prior approval is required for sleep studies performed in any other location that is not the member's home.
Applied behavior analysis (ABA)	Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
Gender reassignment surgery	Prior to surgical treatment of gender dysphoria, the provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and is later modified. Modification can be to the type of treatment, date, time or location of the service/surgery to be provided.
BRCA testing and testing for large genomic re-arrangements in the BRCA1 and BRCA2 genes	Prior approval is required for BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes whether performed for preventive or diagnostic reasons. *Note:* Genetic counseling and evaluation services are required before *preventive* BRCA testing is performed.
Surgical services	Morbid Obesity - See the 2018 Service Benefit Plan Brochure for requirements. Surgical correction of congenital anomalies (see definition in the Service Benefit Plan Booklet); and surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth (see definition in the Service Benefit Plan Brochure). Separate Inpatient (IP) Authorization is needed for all IP admissions.
Hospice care	Prior approval is required for home hospice, continuous home hospice, or inpatient hospice care services. Blue Shield will advise you which home hospice care agencies we have approved. Please contact FEP Care Management at (800) 995-2800.
Organ/tissue transplants – Prior approval is required for both the procedure and the facility	Covered Organ/tissue Transplants - See the list of covered transplant services in the 2018 Service Benefit Plan Brochure. If you travel to a Blue Distinction Center for Transplants, prior approval is also required for travel benefits. The organ transplant procedures must be performed in a facility with a Medicare-Approved Transplant Program. If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply, and you may use any covered facility that performs the procedure. The blood or marrow stem cell transplants listed must be performed in a facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT), or in a facility designated as a Blue Distinction Center for Transplants or as a Cancer Research Facility. Clinical trials for certain blood or marrow stem cell transplants – See the list of conditions covered only in clinical trials in the 2018 Service Benefit Plan Brochure.
Prescription drugs and supplies	Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: 800-624-5077 for the hearing impaired) or visit the FEP CareMark website at: https://www.caremark.com/wps/portal/WEBSUPPORT_FAQS?cms=CMS-PWCM-2034779 to request prior approval, or to obtain a list of drugs and supplies that require prior approval. Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change.
Mail Order Prescription Drug Program	Standard Option members may use our Mail Service Prescription Drug Program to fill their prescriptions. Basic Option members with primary Medicare Part B coverage also may use this program once prior approval is obtained.
Medical foods covered under the pharmacy benefit	Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: 800-624-5077 for the hearing impaired) to request prior approval.

DISEASE MANAGEMENT

*This section was **removed.** Disease Management will be integrated into the Shield Support Care Management program on 1/1/19. The chronic condition language was added to the Care Management section.*

CASE MANAGEMENT *has been changed to* **CARE MANAGEMENT**

***Added** "behavioral health clinicians" to list of providers that make up the Shield Support care teams.*

***Updated** the conditions that the Shield Support program encompasses, as follows:*

Shield Support encompasses a broad spectrum of interventions for short-term care coordination as well as ongoing complex case management for members with the following conditions or utilization:

- Behavioral health
- Cancer
- Cardiovascular, *e.g.*, Coronary Artery Disease, Heart Failure
- Catastrophic injury
- Diabetes
- Musculoskeletal
- Chronic Pain
- Respiratory, *e.g.*, Asthma, COPD
- End-stage renal disease
- Stroke
- Transgender
- Transplant (solid organ and bone marrow)
- Pre-term infants in the Neonatal Intensive Care Unit (NICU) and post NICU
- Plus: ER utilization, post-discharge from hospital, opioid use, high cost and direct referrals

The following services are offered through the Shield Support Care Management Program:

- Telephonic coaching from nurses, behavioral health clinicians, social workers and pharmacists
- Home visits (as needed)
- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- In-person self-management community workshops (for members 18+ years of age)
- Virtual health coaching and cognitive behavioral therapy modules
- Online self-management workshops and educational materials (for members 18+ years of age)

Physician referrals are an important component of Blue Shield's Care Management Programs and may allow for identification of a member more quickly. Blue Shield providers may refer Blue Shield members to our Care Management Programs by submitting the referral form via secure e-mail to bscliaison@optum.com or fax to (877) 280-0179. To download an electronic copy of the referral form, please visit www.blueshieldca.com/provider/guidelines-resources/patient-care/programs.sp. Each referral will be evaluated for eligibility and appropriateness

Musculoskeletal Case Management

*This section was **removed.** Musculoskeletal Case Management will be integrated into the Shield Support Care Management program on 1/1/19 and the program language added to the Care Management section.*

Section 5: Blue Shield Benefit Plans and Programs *(cont'd.)*

CARE MANAGEMENT *(cont'd.)*

Additional Care Management Programs

*The Health Advocate program name was **changed** to Shield Advocate.*

Behavioral Health Condition Management

*This section was **removed.** Behavioral Health Condition Management will be integrated into the Shield Support Care Management program on 1/1/19 and the program language added to the Care Management section.*

***Added** the following new program:*

Landmark Home-Based Care. The Landmark program offers participating chronically ill members 24/7 access to medical professionals and in-home urgent care. Community-based, physician-led medical teams specializing in house calls and home-based care deliver medically needed services to chronically ill patients. Landmark does not replace patients' primary care providers but rather supports the work of patients' existing providers. Landmark clinicians communicate and collaborate with the patients' PCPs and specialists to reinforce the PCP's in-office care plan and provide the attention and care that chronically ill patients with complex health needs may require. Blue Shield identifies eligible members for the Landmark program based on their health and the number and type of chronic conditions they have.

WELLNESS AND PREVENTION PROGRAMS

***Added** the following new program:*

Diabetes Prevention Program

The Diabetes Prevention Program helps members who are at risk of type 2 diabetes lose weight and adopt healthy habits. The program includes 16 weekly sessions over the span of six months followed by monthly maintenance sessions during which members will learn new ways to eat healthier, increase activity, and manage challenges with help from a personal health coach and a small support group. The program is digital or in-person. Members can get started by pre-qualifying at www.solera4me.com/shield.

Section 6: Capitated Hospital Requirements

CAPITATED SERVICES CLAIMS PROCESSING

Billing for Copayments – Commercial

***Updated** language to indicate that copayment amounts are detailed in the Summary of Benefits and Coverage documents found on Provider Connection at https://www.blueshieldca.com/provider/eligibility-benefits/hmo-benefit-summaries/home.sp and are no longer in the HMO Benefit Guidelines.*

Appendices

APPENDIX 4-D LIST OF INCIDENTAL PROCEDURES

Added *the following codes:*

0466T	Insj ch wal respir eltrd/ra
0467T	Revj/rplmnt ch respir eltrd
0468T	Rmvl ch wal respir eltrd/ra
0471T	Oct skn img acquisj i&r addl

Removed *the following codes:*

36120	Establish access to artery
0178T	64 lead ecg w i&r
0179T	64 lead ecg w tracing
0180T	64 lead ecg w i&r only
0294T	Ins lt atrl press mont addon
A9599	Radiopha dx beta amyloid ped

APPENDIX 4-E LIST OF OFFICE-BASED AMBULATORY PROCEDURES

Added *the following codes:*

31298	Nasal sinus endoscopy surgical
36465	Inj noncompounded foam sclerosant
36466	Inj noncompounded foam sclerosant
0465T	Supchrdl njx rx w/o supply
0474T	Insj aqueous drg dev io rsvr
0482T	Absolute quant myocardial bld flow

Removed *the following codes:*

0299T	Esw wound healing init wound
0300T	Esw wound healing addl wound

APPENDIX 5-B OTHER PAYOR SUMMARY LIST

For the most current list, go to Provider Connection at blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards*, then* Other Payor Summary List.

APPENDIX 6-A BLUE SHIELD COMBINED ELIGIBILITY/CAPITATION REPORT

Removed *the "Legacy Data" column on the Commercial report and* ***replaced*** *the Medicare report with a new layout.*

APPENDIX 6-B BLUE SHIELD ELIGIBILITY ADDS AND TERMINATIONS REPORT

Removed *the "Legacy Notes" column on the Commercial report and* ***removed*** *the Medicare report as it no longer applies.*