

October 11, 2019

Subject: **Notification of January 2020 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, 2020.

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 *Guidelines & resources*.

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 2020 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 2020 HOSPITAL AND FACILITY GUIDELINES

General Reminders

Please visit Provider Connection at blueshieldca.com/provider for updated Forms, Member Rights and Responsibilities, Authorizations, Claims information, Provider Manuals and much more.

Blue Shield 65 Plus (HMO) plan name change

The Blue Shield 65 Plus (HMO) plan has changed names. It is now called the **Blue Shield Medicare Advantage plan**. When the manual references Blue Shield Medicare Advantage plan, it refers to Blue Shield's Medicare Advantage plans; Blue Shield 65 Plus (HMO), Blue Shield Plus Choice Plan (HMO), Blue Shield Trio Medicare (HMO), Blue Shield Inspire (HMO), Blue Shield Vital (HMO), and Blue Shield Medicare (PPO).

Section 1: Introduction

MEMBER GRIEVANCE PROCESS - EXPEDITED REVIEW

***Added** language to the Expedited Review process, indicating that the Blue Shield Grievance Process allows members to file grievances within 180 days following any incident or action that is the subject of the enrollee's dissatisfaction.*

BLUE SHIELD'S CODE OF CONDUCT AND CORPORATE COMPLIANCE PROGRAM

***Added** new sections on privacy and security and privacy risks of medical devices.*

Privacy and Security

The Privacy Office provides oversight of Blue Shield's compliance with state, federal, and international privacy laws, including the privacy components of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

The Privacy Office accomplishes its mission of ensuring compliance with these laws and regulations via employee awareness and training programs, outreach, audits, policy development, incorporation of industry best practices, investigations, and through consultation and guidance provided to business units.

For additional information about confidentiality, privacy and security, please contact Blue Shield's Privacy Office Helpline at (888) 266-8080 or Hotline at (855) 296-9086.

Section 1: Introduction (cont'd.)

Privacy and Security Risks of Medical Devices

There are several compliance risks associated with medical devices that can adversely affect healthcare organizations. Medical equipment and devices can contain electronic protected health information, which means any devices that are lost, stolen, or accessed by unauthorized individuals can result in privacy incidents that must be investigated, and potentially reported as breaches. Blue Shield suggests the following safeguards that hospitals can take to lower the risk of their medical devices being hacked:

1. Medical equipment should be assigned to hospital personnel. This provides accountability as well as ensuring software is routinely updated and missing equipment is reported immediately. The average hospital has 10 to 15 medical devices per hospital bed. With many devices operating 24/7, this creates countless entry point opportunities for hackers.
2. Medical equipment and devices that require a user name and password should be unique to each user. Some medical equipment and devices are installed with default user IDs and passwords. User names, passwords, and scannable badges should not be shared among personnel. Different passwords should be used for each piece of medical equipment that connects to the hospital's systems directly, using Wi-Fi, or other internet connection. Further, if a vendor controls the software upgrades, lists of authorized users, passwords, etc., require that the vendor keep the security software current and assigns different passwords for each piece of equipment. This will help prevent hacking all equipment if access is gained through one device.
3. Medical equipment and devices are not generally designed to be remotely managed. The timeframe for an idle user should be limited after sign-on, so that another person cannot access the device under the previous user's credentials.
4. Medical equipment and devices that are equipped with location capabilities should have those capabilities activated at all times. This will help locate lost or stolen equipment.
5. Medical equipment and devices with external USB ports should be covered if possible, to prevent the introduction of malware from an external storage device. In addition, hospital staff should refrain from sharing any Wi-Fi passwords with customers.

Hospital personnel who take these suggested actions will help lower the facility's risk for hacking through its medical equipment and devices.

Section 2: Hospital and Facility Responsibilities

QUALITY MANAGEMENT AND IMPROVEMENT

Accreditation

Expanded the definition of the Health Plan Accreditation process, as below:

Blue Shield maintains Health Plan Accreditation (HPA) status with National Committee for Quality Assurance (NCQA). Blue Shield of California takes the following product types through NCQA accreditation: Commercial HMO/POS, Commercial PPO, Marketplace HMO/POS (Covered CA/Exchange), Marketplace PPO (Covered CA/Exchange) and Medicare HMO. The NCQA review process is an ongoing quality assurance and improvement process that culminates in an audit of health plan performance on NCQA standards every three years. Health Plan scores are evaluated based on audit outcomes and yearly review of health plan scores relative to other plans on key HEDIS and CAHPS measures.

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

Reporting Hospital-Acquired Conditions to CMS

Added language in order to comply with Covered California requirements, as below:

Blue Shield is actively working towards improvement of Hospital Acquired Conditions for all contracted hospitals. In order to comply with Covered California's requirements that all hospitals achieve infection rates (measured as a standardized infection ratio or SIR) of 1.0 or lower, Blue Shield may reserve the right to promote hospital involvement in a performance improvement plan for Hospitals performing in the bottom quartile.

Added updated quality of care reviews section, as below. This section was previously found in Section 3: Medical Care Solutions.

Quality of Care Reviews

Blue Shield has a comprehensive review system to address potential quality of care concerns. A potential quality issue arising from member grievances or internal departments is forwarded to the Blue Shield Quality Management Department where a quality review nurse investigates and compiles a care summary from clinical documentation including a provider written response, if available. The case may then be forwarded to a Blue Shield Medical Director for review and determination of any quality of care issues. A case review may also include an opinion about the care rendered from a like-peer specialist and/or review by the Blue Shield Peer Review Committee.

During the review process, requests for additional information may be made to the Facility. Upon review completion and dependent upon the severity of any quality findings identified, follow-up actions may be taken and can include a corrective action request or an educational letter outlining opportunities for improvement. Patient safety concerns or patterns of poor care can be considered during Blue Shield re-credentialing activities or reviewed in more detail by the Credentials Committee.

Contracted facilities are obligated to participate in quality of care reviews and provide requested documents. Peer review activities are considered privileged communication under California Health and Safety Code section 1370 and California Evidence Code 1157. As such, neither the proceedings or record of the review may be disclosed outside of the review process.

LANGUAGE ASSISTANCE FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY (LEP)

Blue Shield's threshold languages for 2020 are: **Chinese – Traditional, Spanish and Vietnamese.**

Updated the fax number where Language Assistant Forms are sent to. The new fax number is (248) 733-6331.

Section 3: Medical Care Solutions

ADMISSION AUTHORIZATION

Ambulatory Surgeries/Procedures

Removed language in strike through font below to align with current processes:

Office-based ambulatory surgeries/procedures (minor procedures) should be performed in a physician office setting. If it is medically necessary that they be performed in a facility setting, on an outpatient or inpatient basis, notification to Blue Shield Medical Care Solutions is required. If an IPA or medical group schedules an office-based surgery/procedure in an outpatient facility setting, the hospital should confirm that the IPA provided notification to Blue Shield Medical Care Solutions. ~~or the IPA/medical group will be financially responsible.~~

Section 3: Medical Care Solutions (cont'd.)

ORGAN AND BONE MARROW TRANSPLANTS

Removed the following language. Blue Shield no longer follows this process.

For members living in California, referrals to an out of state transplant facility must be at the referral of a Blue Shield's Major Organ/Bone Marrow Transplant Network facility approved for the specified type of transplant based upon medical necessity. For coverage, all referrals for medical necessity to an out-of-state provider must be pre-authorized by a Blue Shield Medical Director.

Updated transplant prior authorization language for Blue Shield Medicare Advantage and Commercial HMO and PPO plans, in boldface type below:

Blue Shield Medicare Advantage plan – Prior authorization for all Blue Shield **Medicare Advantage plan** evaluations and transplants is required and coverage subject to applicable Medicare coverage guidelines. These services must be performed at a Medicare-approved transplant facility for the specific transplant in question. The evaluation for Blue Shield **Medicare Advantage** members requires authorization **by Blue Shield for members in a PPO product**, and by the IPA/medical group **for members in an HMO product**.

Commercial HMO and PPO – For HMO members, both the transplant evaluation and actual transplant procedure require prior authorization. The evaluation for HMO members requires authorization by the IPA/medical group or as otherwise specified. No self-referrals for transplant evaluations will be approved under the POS. For PPO members, **with the exception of IFP PPO**, the evaluation requires notification only. All Blue Shield members are entitled to transplant evaluations at any Blue Shield transplant network facility approved for the specified organ or transplant type, whether or not that facility has a contractual relationship with the IPA/medical group.

ADMISSION AND CONCURRENT INPATIENT REVIEW

Added language below regarding maternity admissions for routine deliveries:

Authorization 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.

QUALITY OF CARE REVIEWS

*This section was **moved** to Section 2: Hospital and Facility Responsibilities.*

BLUE SHIELD MEDICAL & MEDICATION POLICIES

Medication Policy

Updated language below regarding additional authorizations and services that are not medically necessary:

Additional authorization for select medical drugs may also be required for the administration of the drug at an outpatient hospital facility site in addition to authorization of coverage for the drug. Refer to the medication policy. For Blue Shield Medicare HMO and PPO Members, Blue Shield follows Medicare national and local coverage guidelines. For Blue Shield Medicare PPO Plans, Blue Shield Medication Policies and Step Therapy requirements may also apply for select medications.

If Blue Shield determines that a previously rendered service is not medically necessary, or does not qualify for coverage, the provider will not be paid for the service and will not be able to collect payment from the member without a signed notice of non-coverage.

Section 4: Billing and Payment

CLAIMS SUBMISSION

UB 04 Form Locators

Updated definition for Type of Bill (Form Locator 4) as below:

Type of Bill (Form Locator 4) – Submit the type of bill. Note: This is a four-digit alphanumeric code. The fourth digit indicates the sequence of the bill in the episode of care and is referred to as a “frequency” code. If the 4th digit is billed as 0 (zero), the claim is defined as a “Nonpayment/Zero Claims” and will not be considered for payment.

SPECIAL BILLING SITUATIONS

Skilled Nursing (Medicare)

Changed the required billing code from RUG to SNF HIPPS in boldface type below:

Providers must supply the **appropriate CMS Skilled Nursing Facility Health Insurance Prospective Payment System (“SNF HIPPS”)** code and zero charges. This information is required in order to price the claim at the Medicare rates. If the **SNF HIPPS(s)** code is not on the claim, the claim shall default to the lowest **SNF HIPPS(s)** level for the provider’s locality for determining reimbursement in accordance with the Provider’s Agreement. Refer to the Medicare Claims Processing Manual Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated Billing.

FACILITY COMPLIANCE REVIEW

Added specific records that Blue Shield may request to complete a billing audit in boldface type below:

To complete an audit as expeditiously as possible, Blue Shield may ask a hospital to submit medical records; **Emergency Room Notes, Trauma Flowsheet, Physician Progress Notes, Physician Orders, History and Physical, Consultations, Discharge Summary, Operative Report and Implant Log**. Blue Shield may request a copy of the UB 04 (or successor) and a detailed itemization if the claim has been electronically submitted. Timely submission of requests will expedite claims processing.

Section 5: Blue Shield Benefit Plans and Programs

MEDICARE PART D

Medication Therapy Management Program

Added the following condition to chronic conditions that the MTMP addresses:

- Dyslipidemia

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

Added the following section detailing the new Blue Shield Medicare Advantage PPO plan. Sections detailing **Premiums and Copayments or Coinsurance, Blue Shield Medicare (PPO) Benefits, and Exclusions to Blue Shield Medicare (PPO) Benefits** have also been included.

BLUE SHIELD MEDICARE (PPO) (MEDICARE ADVANTAGE)

Blue Shield Medicare (PPO) is Blue Shield's Medicare Advantage-Prescription Drug (MA-PD) plans. These plans are open to all Medicare beneficiaries, including those under age 65 who are entitled to Medicare on the basis of Social Security disability benefits, who meet all of the applicable eligibility requirements for membership, have voluntarily elected to enroll in Blue Shield Medicare (PPO), have paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield Medicare (PPO), has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Blue Shield Medicare (PPO) is offered to individual Medicare beneficiaries and to group Medicare beneficiaries retired from employer groups/unions who have selected the product as an option.

To be eligible for enrollment in the Blue Shield Medicare (PPO) program, the member must have both Medicare Part A and Medicare Part B and live within the CMS-approved Blue Shield Medicare (PPO) service area. Patients diagnosed with End Stage Renal Disease (ESRD) prior to signing an enrollment application, who have ongoing dialysis, are not eligible to join Blue Shield Medicare (PPO), unless they are already a Blue Shield commercial plan member and within their 30-month coordination period or were previously enrolled with another Medicare Advantage PPO that has subsequently withdrawn from their county. Once a kidney transplant has occurred and the individual no longer needs dialysis, he or she is eligible to enroll in Blue Shield Medicare (PPO). All other pre-existing conditions are covered without a waiting period.

The Blue Shield Medicare (PPO) plan members may self-refer to any provider. The highest benefits level (i.e., lowest out-of-pocket costs) will be paid when a Blue Shield Medicare Preferred Provider is used. A member's copayments and deductible amounts for covered services will vary depending on whether he or she selects a preferred hospital provider or a non-network hospital provider. Therefore, there is a financial incentive for members to use Blue Shield Medicare preferred hospital providers.

The Blue Shield Medicare (PPO) plan is regulated by the Centers for Medicare & Medicaid Services (CMS), the same federal agency that administers Medicare. Please contact Blue Shield Medicare Advantage plan Member Services (877) 654-6500 (for Providers), (800) 776-4466 (for Members), if you have questions about benefit information, eligibility, claims, and/or billing.

Individual Blue Shield Medicare (PPO) Service Area

| |
|---------|
| Alameda |
|---------|

Added the following section:

NATIONAL MEDICARE COVERAGE DETERMINATIONS

A National Coverage Determination (NCD) is a national policy determination made by CMS regarding the coverage status of a particular service under Medicare. A NCD does not include a determination of what code, if any, is assigned to a service or a determination about the payment amount for the service.

National Medicare Coverage Determinations that arise between contract years allow Medicare Advantage Organizations and contracted providers to bill Medicare on a fee-for-service basis for newly covered items that exceed the significant cost criterion.

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

NATIONAL MEDICARE COVERAGE DETERMINATIONS (cont'd.)

When the significant cost criterion is not met:

The MAO is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date of the NCD or as of the date specified in the legislation/regulation.

When the significant cost criterion is met:

The MAO is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the significant cost of the service or benefit. However, a plan must pay for the following:

Diagnostic services related to the NCD item, service, or legislative change in benefits and most follow-up services related to the NCD item, service, or legislative change (42 CFR § 422.109(c)(2)(i), (ii));

NCD items, services, or legislative change in benefits that are already included in the plan's benefit package either as Original Medicare benefits or supplemental benefits.

Billing to Medicare must include a notice that the item being billed involves a new coverage issue and that the person or organization submitting the bill is requesting fee-for-service reimbursement.

For select medications, Blue Shield Medicare PPO Medication Policies and Step Therapy requirements may also apply. The Blue Shield Medicare (PPO) benefit for medication coverage under the benefit can be found on Provider Connection at blueshieldca.com/provider under Authorizations, Clinical Policies and Guidelines, and then Medication Policy List.

For more information on NCDs, go to the Medicare Coverage Database on the CMS.gov website at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

FEDERAL EMPLOYEE PROGRAM (FEP)

About the BlueCross and BlueShield Service Benefit Plan

Added *FEP Blue Focus to list of benefits offered by FEP.*

Noted *that FEP Blue Focus and Basic Option members must seek care from in network providers to be covered for any services and care received outside the United States, Puerto Rico and the U.S. Virgin Islands must be pre-approved.*

Precertification for Inpatient Hospital Admissions

Added *language in boldface type below:*

Precertification is not needed for a maternity admission for a routine delivery. **However, if the mother's medical condition requires her to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, the physician or the hospital must contact Blue Shield for precertification of additional days. Further, if the baby stays after the mother is discharged, then the physician or the hospital must contact Blue Shield for precertification of additional days for the baby.**

Note: *When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.*

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

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

Required Prior Authorization

Updated the following services requiring prior authorization:

| Prior Approval is required for: | Additional Information |
|---|---|
| BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes | <p>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.</p> <p><i>Note:</i> Necessary medical evidence for BRCA related genetic testing includes the results of genetic counseling. Genetic counseling and evaluation services are required before <u>preventive</u> BRCA testing is performed.</p> |
| Surgical services | <p>Morbid Obesity - See the Blue Cross Blue Shield Service Benefit Plan Brochure for requirements.</p> <p>Surgical correction of congenital anomalies; and oral maxillofacial surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth (see definitions in the Service Benefit Plan Brochure).</p> <p>Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ).</p> <p>Breast reduction or augmentation not related to treatment of cancer.</p> <p>Reconstructive surgery for conditions other than breast cancer.</p> <p>Orthopedic procedures: hip, knee, ankle, spine, shoulder and all orthopedic procedures using computer-assisted musculoskeletal surgical navigation.</p> <p>Rhinoplasty, Septoplasty and Varicose vein treatment.</p> <p>Separate Inpatient (IP) Authorization is needed for all IP admissions.</p> |
| Transplants – Prior approval is required for both the procedure and the facility | <p>Prior Approval is required for all transplants, except cornea and kidney. Covered Organ/tissue Transplants - See the list of covered transplant services in the Blue Cross Blue Shield Service Benefit Plan Brochure.</p> <p>If you travel to a Blue Distinction Center for Transplants, prior approval is also required for travel benefits.</p> <p>The organ transplant procedures must be performed in a facility with a Medicare-Approved Transplant Program. Medicare's approved programs are listed at: https://qcor.cms.gov/main.jsp</p> <p>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.</p> <p><i>Note:</i> For the purposes of the blood or marrow stem cell clinical trial transplants covered under this Plan, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board (IRB) of the FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility where the procedure is to be performed. Clinical trials for certain blood or marrow stem cell transplants – See the list of conditions covered only in clinical trials in the Blue Cross Blue Shield Service Benefit Plan Brochure.</p> <p>All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact Blue Shield at the customer service telephone number listed on the back of their ID card before obtaining services.</p> |

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

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

Required Prior Authorization (cont'd.)

Added the following services requiring prior authorization:

| Prior Approval is required for: | Additional Information |
|---|--|
| Specialty DME | Specialty hospital beds, deluxe wheelchairs, power wheelchairs and mobility devices including scooters and related supplies. |
| Gene Therapy and Cellular Immunotherapy | Including Car-T and T-cell receptor therapy. |
| Air Ambulance Transport (Non-Emergent) | Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval. |
| Outpatient Intensity Modulated Radiation Therapy (IMRT) | Prior approval is required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, prostate or anal cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer. |
| Rehabilitation Services | Cardiac Rehab and Pulmonary Rehab. |
| Devices | Cochlear implants and external prosthetic devices, including microprocessor controlled limb prosthesis and electronically and externally powered prosthesis. |
| Outpatient Residential Treatment Center Care | For any condition. |
| High tech Radiology | MRI, CT and PET scans. Note: High technology radiology related to immediate care of a medical emergency or accidental injury does not require prior approval. |

MEDICARE SUPPLEMENT PLANS

Claims Assignment

Updated plan, group numbers and claims information for Medicare Supplemental plans and Group plans:

| Plan and Group Numbers | Medicare Unassigned Claims |
|-------------------------------|--|
| Benefit Plan A, B, C, D, H, K | Patients pay balance of billed charges (limiting charge).* |
| Benefit Plan F, I, J | Blue Shield pays 100% of the difference between Medicare's payment and billed charges. |
| Benefit Plan G | Blue Shield pays 80% of the difference between Medicare's payment and billed charges. Patients pay balance of billed charges.* |
| Golden Coronet Senior | Blue Shield pays 80% of the difference between Medicare's payment and billed charges. Patients pay balance of billed charges.* |
| Coronet Major Medicare | Patients pay balance of billed charges (limiting charge).* |
| Coronet Senior | Patients pay balance of billed charges (limiting charge).* |
| Preferred Senior | Patients pay balance of billed charges (limiting charge).* |

**Not to exceed the Medicare limiting charge or billed charge, whichever is less.*

CARE MANAGEMENT

Updated the Prenatal Program language to support the AB 2193 mandate, as follows:

Prenatal Program. This program is designed to improve the quality of care received before and during pregnancy and to reduce the costs associated with high-risk pregnancies, while helping women have healthy pregnancies and healthy babies. Our Prenatal Program utilizes a whole-person approach by addressing our members' physical health and mental well-being throughout her pregnancy.

WELLNESS AND PREVENTION PROGRAMS

*The Daily Challenge, QuitNet, and Walkadoo Programs **have been replaced** with Wellvolution:*

Wellvolution

Wellvolution has been redesigned to give members the tools for obtaining optimal health, whether that means staying fit, preventing disease, or treating existing conditions.

Here's how it works: A member creates a new account and sets health goals. Wellvolution customizes the path to better health, matching the member with programs and popular apps that are personalized and have proven results.

At no extra cost, members get access to easy, customized plans and popular apps, like Pacifica, Yes Health and Weight Watchers, that fit their path. No matter where they are on their health journey, Wellvolution will help members reach their goals. Visit www.wellvolution.com to get started.

Programs are broken into three categories:

1. Wellvolution Lifestyle programs – a hand-selected set of proven general well-being programs, designed to help generally healthy members achieve their health goals of sleeping better, lowering stress, exercising more, eating better or quitting smoking. Many of these programs are available in their market 'free' version, with upgrades available at the member discretion.
2. Wellvolution Disease prevention programs – high touch programs, often incorporating in-person or digital coaching options, digital tools and frequent engagement are geared toward prevention of diseases like type 2 diabetes or heart disease using proven lifestyle medicine methodology. These programs are fully covered by Blue Shield of California.
3. Wellvolution Condition reversal programs – high touch programs, often incorporating in-person or digital coaching options, digital tools and frequent engagement are geared toward reversal and treatment of existing chronic conditions using proven lifestyle medicine methodology. These programs are fully covered by Blue Shield of California.

Diabetes Prevention Program

*The Diabetes Prevention Program **can now be accessed** through the Wellvolution platform at www.wellvolution.com.*

Wellness Discount Programs

***Removed** Weight Watchers, ClubSport, and 24-Hour Fitness and **added** Fitness Your Way by Tivity to wellness discount programs.*

PATIENT ALLY

***Removed** this section. Information about Patient Ally can be found on Provider Connection at blueshieldca.com/provider.*

Appendices

APPENDIX 4-B BLUE SHIELD MEDICARE ADVANTAGE PLAN REQUIRED BILLING ELEMENTS

Updated steps #8, #9 and #10 of the Appeal Process for Notice of Non-Coverage HHA, SNF, CORF, in boldface and strike through font below:

| # | Responsible Party | Activity | Time Requirement |
|-----|--------------------------------------|--|--|
| 8. | IPA/MSO | <p>Faxes records to:</p> <p>1.) Health Services Advisory Group, Inc.</p> <p>Copy of NOMNC with member's signature or documentation of refusal to sign, copy of DENC and copy of enrollee's medical records.</p> <p>2.) Blue Shield 65 Plus (HMO):</p> <p>Cover sheet confirming documentation was sent to Health Services Advisory Group, Inc., copy of NOMNC with member's signature or documentation of refusal to sign & copy of DENC</p> <p>2.) Member/representative:</p> <p>Mails DENC. Upon request, all documents sent to Health Services Advisory Group, Inc.</p> | Day 1 |
| 9. | IPA/MSO BSC | <p>HMO ONLY: IPA makes decision to rescind the termination date and send new letter to member.</p> <p>Fax copy of letter to Health Services Advisory Group, Inc.</p> <p>PPO ONLY: Blue Shield makes decision to rescind the termination date and send new letter to member.</p> <p>Fax copy of letter to Health Services Advisory Group, Inc.</p> | <p>Resolved Go to step 14</p> <p>Resolved Go to step 14</p> |
| 10. | Health Services Advisory Group, Inc. | <p>Reviews documents.</p> <p>Renders decision to uphold or overturn.</p> <p>Notifies IPA & Blue Shield Medicare Advantage plan of decision by phone or fax. Mails letters of determination to Blue Shield Medicare Advantage plan and enrollee.</p> | <p>Day 1</p> <p>If Resolved Go to step 14</p> |

APPENDIX 4-D LIST OF INCIDENTAL PROCEDURES

Added the following codes:

| | |
|-------|------------------------------|
| 10004 | Fna bx w/o img gdn ea addl |
| 10006 | Fna bx w/us gdn ea addl |
| 10008 | Fna bx w/fluor gdn ea addl |
| 10010 | Fna bx w/ct gdn ea addl |
| 10012 | Fna bx w/mr gdn ea addl |
| 11103 | Tangntl bx skin ea sep/addl |
| 11105 | Punch bx skin ea sep/ addl |
| 11107 | Incal bx skn ea sep/addl |
| 20932 | Osteoart algrft w/surf & b1 |
| 20933 | Hemicrt intrclry algrft prtl |
| 20934 | Intercalary algrft compl |
| 27369 | Njx Cntrst kne arthg/ct/mri |
| 33866 | Aortic hemiarch graft |
| 0513T | Esw integ wnd hlg ea addl |
| 0514T | Intraop vis axis id pt fixj |
| 0523T | Ntrapx c ffr w/3d funcil map |

Removed the following codes:

| | |
|-------|------------------------------|
| 27370 | Injection for knee x-ray |
| 0346T | Ultrasound elastography |
| 0406T | Sin ndsc plmt drg elut mplnt |
| 0407T | Sin ndsc plmt drg elut mplnt |

APPENDIX 4-E LIST OF OFFICE-BASED AMBULATORY PROCEDURES

Added the following procedure codes:

| | |
|-------|---------------------------|
| 0525T | Insj/Rplcmt Compl IIMS |
| 0529T | Interrog Dev Eval IIMS IP |
| 0530T | Removal Complete IIMS |

Removed the following procedure codes:

| | |
|-------|-----------------------------|
| 11100 | Biopsy, skin lesion |
| 11101 | Biopsy, skin add on |
| 64550 | Apply neurostimulator |
| 0190T | Place intraoc radiation src |

APPENDIX 5-A THE BLUECARD PROGRAM

Submitting BlueCard Claims

Added/removed language addressing options for submitting claims in boldface and strike through font below:

4. If and for so long as the hospital or facility is contracted with both Blue Shield and another licensee of the Blue Cross Blue Shield Association in the State of California, and there is no exclusive arrangement with either Blue Shield nor the other license of the Association, the hospital or facility shall increase the number of claims for medical services process through the BlueCard Program (as defined in the Provider Manual) sent to Blue Shield for processing.
5. **To facilitate the obligation outlined in 4) above, Blue Shield provides clearinghouses and EDI partners* with tools that improve claims processing accuracy and reduce turnaround time. These are collectively known as the BlueCard Prefix Code Routing Table Edit ("BlueCard Edit" or simply, "Edit"). Unless otherwise noted in the Provider Contract, the provider has authorized the implementation and use of these tools for their BlueCard claims in all transmission formats.**

The purpose and functionality of the BlueCard Edit is to direct and route all BlueCard transactions where Blue Shield is eligible to process said claims. This includes all BlueCard transactions that are related to a healthcare member whose healthcare payer is a licensed affiliate of the Blue Cross Blue Shield Association ("BCBSA"). It does not include transactions from prefixes noted in the table that are (i) exclusive to another licensee of the Blue Cross Blue Shield Association in the State of California,; or (ii) from those licensed affiliates of BCBSA that designates another licensee of the Blue Cross Blue Shield Association in the State of California exclusively to process transactions for its members.

*If requested, Blue Shield will provide to the provider or their agents or claims clearinghouse (collectively known as the "SUBMITTER") its proprietary BlueCard Prefix Code (also known as the Interplan Teleprocessing System, or "ITS") table ("Table") which shall at all times remain the Confidential Information of Blue Shield. Upon provision of the Table, the Submitter shall develop, implement, and maintain in production the software functionality or program known as the BlueCard Prefix Code Routing Table edit ("BlueCard Edit" or simply, "Edit"). Where such capability currently exists, the provider hereby authorizes and directs their Submitter to make use of said Edit or similar capability. To inquire about the BlueCard Edit, email BlueCardMarketing@blueshieldca.com.

- ~~5. Request a BlueCard routing option from Blue Shield. The BlueCard routing option is a streamlined IT solution developed by Blue Shield that integrates with a provider's clearinghouse and/or eligibility and benefits verification vendor's system to simplify and automate selecting the correct California Blue plan for processing BlueCard claims. The BlueCard routing option is an alternative to using Blue Shield's Claims Routing Tool on Provider Connection. To inquire about the BlueCard routing option, email BlueCardMarketing@blueshieldca.com.~~

BlueCard Resources

Added language describing new and expanded sections on the BlueCard Program home page at blueshieldca.com/provider for "**BlueCard Videos**" and "**BlueCard FAQs**."

APPENDIX 5-A THE BLUECARD PROGRAM (cont'd.)

Reimbursement for Medicare Advantage PPO, HMO and POS

Added language, as below:

If you are a provider who accepts Medicare assignment, has a Blue plan contract to provide services for all Medicare Advantage enrollees, and you render services to out-of-area Blue Medicare Advantage members, you will be reimbursed at the contracted rate.

Reimbursement for Medicare Advantage Private Fee-For-Service (PFFS)

Added language, as below:

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member and you are obligated to provide services to such member under a contract with a Blue plan, you will generally be reimbursed at your contracted rate.

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, Policies and standards, then Other Payor Summary List on the left.

APPENDIX 6-C CLAIMS COMPLIANCE AND MONITORING

*This appendix was **rewritten** for clarification. Duplicated sections were removed and language relating to regulations were expanded upon.*

This page intentionally left blank.