October 16, 2020

Subject: **Notification of January 2021 Updates to the Blue Shield *Independent Physician and Provider Manual***

Dear Provider:

We have revised our *Independent Physician and Provider Manual.* The changes listed in the following provider manual sections are effective January 1, 2021.

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 *Independent Physician and Provider Manual* be mailed to you, once it is published, by emailing providermanuals@blueshieldca.com.

The *Independent Physician and Provider Manual* is referenced in the agreement between Blue Shield of California (Blue Shield) and those physicians and other healthcare professionals who are contracted with Blue Shield. If a conflict arises between the *Independent Physician and Provider Manual* and the agreement held by the individual and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the January 2021 version of this manual, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091.

Sincerely,

Hugo Florez
Vice President, Provider Network Management
Blue Shield Promise and PPO Specialty Networks

T11242 (10/20)

UPDATES TO THE JANUARY 2021
INDEPENDENT PHYSICIAN AND PROVIDER MANUAL

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.

New Pharmacy Claims Processing Vendor

Effective January 1, 2021, Blue Shield of California will have a new pharmacy claim processing vendor. CVSH will be processing pharmacy claims for all Blue Shield plans. Members will receive new ID cards with updated RxBIN and RxPCN pharmacy information. Direct Member Reimbursement (DMR) forms will be updated to include CVSH information. Members who have questions about their pharmacy benefits should be directed to contact the Customer Care telephone number on their member ID cards.

Section 1: Introduction

ENROLLMENT AND ELIGIBILITY

Added *the new section below:*

Monthly Eligibility Reports (Capitated Providers)

As a cost-effective measure, Blue Shield provides the Combined Eligibility/Capitation Report and the Eligibility Adds and Termination Report only in electronic format. Receiving eligibility information electronically enables capitated providers to use and sort the information in many ways to meet their specific reporting needs.

Blue Shield distributes these eligibility reports via Blue Shield secure email or SFTP to all capitated providers no later than the tenth of each calendar month. For details on the file formats, refer to Appendix 1 in the back of this manual.

Both reports include the member's name and identification number, the member's primary care physician name and identification number, as well as the activity code for all member status changes. The files also include the member's group number and Product IDs. The Product IDs are codes that identify the member's standard office visit copayments. Product IDs and Physician Office Copayment Guides are forwarded each month along with the Combined Eligibility/Capitation Reports.

Section 2: Provider Responsibilities

GENERAL ADMINISTRATIVE CRITERIA

Added *language to align with provider contract language updates regarding maintaining directory data:*

In order to reduce administrative burden on providers, Blue Shield delegates some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the provider must work with the vendor in lieu of Blue Shield to complete directory maintenance tasks. This will entail executing a participation agreement with the vendor and taking other reasonably requested steps to ensure smooth exchange of directory data.

PROVIDER CERTIFICATION

*This section has been **deleted and replaced** with the following language:*

For inclusion in the Blue Shield network, practitioners that include any person licensed or certified to provide member care must meet Blue Shield's network criteria.

To request a new record or to add a provider to a current group record, the provider enrollment and maintenance application can be used, or provider profile with equivalent data elements. To view and download copies of the new forms, please log in to Blue Shield's provider portal at blueshieldca.com/provider, click on *Find forms* at the bottom of the page, then *Network and procedure forms*. Submit the completed application to:

Blue Shield of California Provider Information and Enrollment	
Email	BSCProviderInfo@blueshieldca.com
Postal mail	Provider Information & Enrollment P.O. Box 629017 El Dorado Hills, CA 95762-9017

Reporting Provider Status Changes

To keep Blue Shield records and directories current, Providers are required to notify Blue Shield of changes to demographic data and any changes to their practice. Upon notification of status changes, Blue Shield will update its provider database and directories accordingly.

The provider group or practice is required to notify Blue Shield of changes to its provider network, as follows:

- **Addition of New Providers**

  The medical group must notify Blue Shield 30 days prior to the date a new provider is added to the IPA/medical group. The medical group is required to send a practitioner profile for all new providers participating with a relationship to the medical group.

  Delegated Medical Groups may send new provider profiles directly to the Provider Information & Enrollment team to be added to the network relationship. Non-delegated Medical Groups must first submit a credentialing application with new provider profiles and receive credentialing approval prior to provider being added to the network.

  Blue Shield will not add a provider who does not meet Blue Shield Network Criteria, including eligibility to participate in any Blue Shield networks the IPA/Medical Group is contracted for.

  Blue Shield will not add a provider whose service location is outside Blue Shield's approved network.

- **Demographic/Administrative Changes**

  The provider or medical group must notify Blue Shield of demographic or administrative changes as soon as possible for timely directory updates. Examples of these types of demographic or administrative changes include office location, office hours, office email, telephone numbers, fax numbers, billing address, tax identification number, board status, key contact person, etc.

  The minimum required data for all new providers and provider demographic adds, updates, or termination submissions is as follows.

  - Complete name
  - Primary office locations
  - Telephone number and fax number, if applicable

- **Demographic/Administrative Changes** *(cont'd.)*
  - Office hours
  - Specialty
  - California license number
  - Hospital staff privileges (list hospitals and types of privilege)
  - Languages spoken
  - Wheelchair access
  - IRS number
  - NPI
  - Designation as PCP or specialist or both (if applicable)
  - Panel data including gender, age or patient restriction
  - Identification of the IPA to which the practitioner should be added
  - Where required by law, individuals requiring supervision must also provide the name, NPI and license number of the supervising physician.
- **Credential Status Changes**

  Providers also are required to notify Blue Shield Provider Information & Enrollment whenever there are changes in their individually licensed provider's credentials status (e.g., license status, state probation, liability carrier, accusation, etc.), as well as changes in their practice location and demographic information.

The appropriate documents required for reporting various changes are noted below. Provider Practice or Facility changes require appropriate documentation to verify the data.

Type of Change	Reporting Document
Incorporating practice	Written request, including Articles of Incorporation, And tax verification document (W-9, Tax Coupon, SS-4, Letter 147-C)
Changing name of group	Agreement and tax verification document Information Change Form* (W-9, Tax coupon, SS-4 or letter 147C from IRS)
Changing Tax ID number of group	Agreement and tax verification document Information Change Form* (W-9, Tax coupon, SS-4 or letter 147C from IRS)

** In addition to the Agreement and Information Change Form, when applicable, Articles of Incorporation and/ or a Fictitious Name Permit from the Medical Board of California are required. Please include the current roster of providers for each location. The group is responsible for continually updating changes in its roster. For additional information regarding changing a group EIN, please contact Provider Information & Enrollment at (800) 258-3091*

** Credentialing requirements will need to be met. Please see the following pages for additional information.*

Note: The Record Application Form and Information Change Form are not an agreement and can only be used for billing purposes in absence of a fully executed and countersigned agreement by Blue Shield. Additionally, billing for providers who are not certified by Blue Shield as members of the group will subject the group to immediate termination as a Blue Shield provider.

QUALITY MANAGEMENT AND IMPROVEMENT

Accreditation

Added Medicaid *to list of product types that Blue Shield takes through NCQA accreditation.*

Provider Responsibilities for Quality Management and Improvement

Added *the following to the quality improvement activities that Blue Shield seeks provider representatives' participation in:*

- Investigation of member grievances and quality of care concerns

Deleted *the language in boldface type below:*

Quality management activities are considered privileged communication in conjunction with peer review activities conforming to Evidence Code Section 1157 and Section 1370 of the California Health and Safety Code. **As such, neither the proceedings nor the records of the review may be disclosed to any person outside of those participating in the review process.**

HOME-BASED PALLIATIVE CARE PROGRAM PROVIDERS

Assessing/Enrolling a Member

Updated *the enrollment notification timeline in boldface type below:*

Home-based palliative care program providers are responsible for assessing whether a member qualifies for the program after a referral has been made. The assessment must be completed within **three (3)** business days of the receipt of the referral or, in the case of a hospitalized member, within **three (3)** days of the member's discharge from the hospital.

Disenrolling a Member

Updated *the disenrollment notification timeline in boldface type below:*

Blue Shield must be notified of a member's disenrollment from the program within **three (3)** days of the member's disenrollment, as specified in the agreement, via email sent to BSCPalliativeCare@blueshieldca.com.

Engaging the Palliative Care Team

Added *the following best practices of the Palliative Care Team:*

As a best practice, a member of the palliative care team should visit patients monthly. These visits can be completed by, video, phone or face to face.

It is required that a Blue Shield Clinical Program Manager attend monthly IDT meetings to discuss currently enrolled patients. It is the responsibility of the provider to schedule the IDT meetings and send invites to the assigned Blue Shield Clinical Program Manager. You will be required to submit monthly clinical documentation on all currently enrolled members. Please submit the clinical documentation to BSCPalliativeCare@blueshieldca.com.

Quality Review Guidelines

*This section has been **deleted and replaced** with the following language:*

The process for the review is:

- Monthly: Providers will complete the utilization report and the enrollment/disenrollment report. Providers have 7 days to submit both reports to Blue Shield Palliative Care team.
- Blue Shield Palliative care team will work with providers to set acceptable targets. Blue Shield will provide feedback on the monthly quality reviews and discuss any issues arising from Blue Shield's ongoing and systematic utilization review during the quarterly operation calls.
- Additional quality and performance improvement coaching will be scheduled if needed.

Blue Shield retains the right to audit providers to ensure quality of care at any time and without notice.

Completing the Biweekly requirement

*This section has been **rewritten** to highlight required reporting documents and how to fill them out and submit them to Blue Shield.*

SERVICE ACCESSIBILITY STANDARDS

*Access standards for the following topics have been **deleted and replaced** with the grids below:*

Behavioral Health Appointment Access Standards

CATEGORY	ACCESS STANDARDS
Routine office visit (including non-physician providers)	Within 10 business days
Urgent Care	Within 48 hours
Emergency Care, non-life threatening	Within 6 hours
Follow-Up Routine Care (including a non-physician mental health care provider)	Within 30 Calendar Days Follow-up routine care appointments are visits at later, specified dates to evaluate the patient progress and other changes that have taken place since a previous visit.

Provider Availability Standards for Commercial Products

Blue Shield has provider availability standards to ensure a network of established primary care physicians (PCPs) and high-volume specialty practitioners that is sufficient in number and geographic distribution for Commercial and Medicare Advantage members. Please refer to the provider availability standards below.

Provider Availability Standards for Commercial Products *(cont'd.)*

Geographic Distribution

CATEGORY	PRODUCT TYPE	STANDARD	COMPLIANCE TARGET
Total PCPs	HMO/POS PPO - CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	One PCP within 15 miles or 30 minutes of each member	100%
PCP **General Practitioner** **Family Practitioner** **Internist** **Pediatrician**		One PCP within 15 miles or 30 minutes of each member	100%
Obstetrician/Gynecologist		One OB/GYN within 30 miles of each member (non-Medicare)	85%
High Volume Specialists		One of each type of Top High Volume Specialists within 30 miles of each member	90%
Hospitals		One hospital within 15 miles of each member	85%
Radiology		One Radiology facility in 30 miles	90%
Lab		One lab in 30 miles	90%
Pharmacy		One Pharmacy in 10 miles	95%
DME		One DME in 15 miles	85%
ASC		One ASC in 30 miles	95%
SNF		One SNF in 30 miles	95%
Urgent Care		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: I in 30 miles	90% 85% 75%
Dialysis		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: I in 30 miles	90% 85% 75%
Acupuncturist	PPO	1 in 15 miles Or 1 in 30 minutes	90%

Provider Availability Standards for Commercial Products *(cont'd.)*

Provider-to-Member Ratio

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
PCP Family Practitioner, General Practitioner, Internist Pediatrician	HMO DCHMO	One PCP to 2,000 commercial members	100%
Top High Volume Specialties and High Impact Specialties to Member Ratio	HMO PPO-DMHC IFP-ePPO	1 OB/GYN to 10,000 female members. 1 High Volume Specialty of each type and 1 High Impact Specialty to 20,000 members.	100%
Acupuncturist to Member Ratio	PPO	One Acupuncturist to 5,000 commercial members	100%
Ethnic/Cultural and Language Needs	HMO/POS PPO – DMHC	1 PCP speaking a threshold language to 1,200 members speaking a threshold language**	100%

*PPO plans are both Blue Shield PPO – DMHC and PPO – CDI plans. PPO membership excludes ASO/self-insured business.

** Threshold languages are: Spanish, Chinese – Traditional, and Vietnamese

Additional Measurements for Multidimensional Analysis for Commercial Products

METRICS	PRODUCT	STANDARD	FREQUENCY
Access related member complaints and grievances	HMO/POS/ PPO	Rate of complains/grievances ≤1 per thousand members per month (non-Medicare) Rate of complains/grievances ≤5 per thousand members per month (Medicare)	Assessed Quarterly against Standard
Availability-related PCP Transfers	HMO	Rate of PCP transfers 1.68 per thousand members per month (Medicare)	Assessed Quarterly against Standard
PCP Turnover	HMO/POS	14%	Assessed Quarterly against Standard
PCP, Specialist, and Hospital Network Change Analysis	IFP ePPO	10% change	Assessed Quarterly against Standard
PCP to Member Ratio	IFP PPO	1:2000	Quarterly

Top HVS Turnover	HMO/PPO/ CDI/ SHOP HMO/PPO	10%	Assessed Quarterly against Standard
Hospital Turnover	HMO/PPO	5%	Ad hoc for Block Transfer Filings and 10% Change Analysis
Open PCP Panel	HMO/POS/ Directly Contracted HMO	85%	Assessed Quarterly against Standard
Member Satisfaction	HMO/POS/ PPO	HMO – Patient Assessment Survey at IPA/MG level HMP/PPO – CAHPS at Health Plan level	Annual

*Access standards for the following topics have been **added** with the grids below:*

ACCESS TO TELEPHONE SERVICE	STANDARD
Average Speed to Answer (ASA)	30 seconds
Abandonment Rate	≤ 5%
Blue Shield's **24/7 Nurse Advice Line** will be available for all enrollee triage and screening needs. The speed to answer will be:	Within 30 minutes
Access to the **Blue Shield Customer Service** line during normal business hours	Within 10 minutes

Additional Measurements for Multidimensional Analysis for Medicare Advantage Products

METRICS	COMPLIANCE TARGET	FREQUENCY
Availability related member complaints and grievances	Rate of complaints and grievances 8.81 PTM	Semi-Annual
Availability related PCP Transfers	Rate of PCP transfers per thousand members 1.68 PTM	Semi-Annual
PCP Turnover Rate	14%	Semi-Annual
Top 10 HVS Turnover Rate	10%	Semi-Annual
Hospital Turnover Rate	5%	Semi-Annual
Open PCP Panels	85%	Semi-Annual
PCP to Member Assignment Ratio	1: 1200	Semi-Annual
High Volume and High Impact Specialist to Member Ratio	1:20,000	Annual

Section 3: Medical Care Solutions

MEDICAL CARE SOLUTIONS PROGRAM OVERVIEW

Added *the following language regarding medical necessity:*

The Medical Care Solutions Program is designed to assist Blue Shield contracted physicians, providers, and hospitals in ensuring the coverage of medically necessary services.

Medical necessity is defined as follows:

Only those services which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are:

- consistent with Blue Shield Medical Policy;
- consistent with the symptoms or diagnosis;
- not furnished primarily for the convenience of the patient, the attending physician, or other provider; and
- furnished at the most appropriate level which can be provided safely and effectively to the patient; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.
- Hospital Inpatient Services which are medically necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a physician's office, an Outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services which are not medically necessary include hospitalization:
- diagnostic studies that can be provided on an Outpatient basis;
- medical observation or evaluation;
- personal comfort;
- Pain management that can be provided on an outpatient basis; and inpatient rehabilitation that can be provided on an Outpatient basis.

Note*: Benefits are provided only for services which are medically necessary.*

Blue Shield reserves the right to review all services to determine whether they are medically necessary, and may use the services of physician consultants, peer review committees of professional societies or hospitals, and other consultants.

MEDICAL CARE SOLUTIONS PROGRAM OVERVIEW *(cont'd.)*

Medical necessity reviews (for both authorizations and non-authorizations) made by Blue Shield use a hierarchy of criteria. (The specific hierarchy can be found on page 24 of the Utilization Management Program Description.) These criteria consist of internal medical policies established by the Blue Shield Medical Policy Committee, nationally recognized evidence-based criteria (currently MCG Care Guidelines) for medical and mental health conditions as well as for substance use disorders, National Imaging Associates (NIA) Radiology Clinical Guidelines, Advisory Committee on Immunization Practices (ACIP), and Medication Policies (for non-self-administered drugs such as Injectable and Implantable drugs) established by the Blue Shield Pharmacy and Therapeutics Committee (these criteria and guidelines are adopted with input from network physicians and are regularly reviewed for clinical appropriateness). Where applicable, criteria established by the Center for Medicare & Medicaid Services (CMS) and DME coverage criteria are utilized. IPA/medical groups are required to ensure that they are using the most current version of the policies and maintain updating their UM review processes. These policies may be found on blueshieldca.com/provider and may be updated quarterly as needed.

BLUE SHIELD MEDICAL & MEDICATION POLICIES

Medication Policy

Added *language in boldface type below regarding additional authorizations and services that are not medically necessary:*

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 **which may require step therapy.**

ORGAN AND BONE MARROW TRANSPLANTS

Added CAR-T Therapy *to list of transplants requiring prior authorization.*

PRIOR AUTHORIZATION

Specialty Drug Prior Authorization for the Medical Benefit

Added *the following language:*

Additionally if the claim does not match the authorization, payment may be denied.

DRUG FORMULARY

Added *language on ways to submit prior authorizations requests:*

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds.

Specialty Drugs

Added *the following language:*

Specialty drugs may be dispensed by any willing pharmacy for Medicare Part D plans.

Section 4: Billing and Payment

CLAIMS SUBMISSION

Added *the section below introducing Real Time Claims Settlement, which is an online feature scheduled to go live on Provider Connection at blueshieldca.com/provider in 2020.*

Real Time Claims Settlement

Real-Time Claims Settlement provides an enhanced provider experience through speed, accuracy and most importantly transparency in the claim's adjudication process. The end goal solution Blue Shield is building toward is an end-to-end automated process from claim creation to payment reconciliation.

Current Enhancements

While we are working to fully automate the transaction process, one of our first steps is the creation of a Real Time Claims Web Tool in Provider Connection. This tool will allow you to estimate and submit claims online to process with a target of 3-9 seconds. While it does take some data entry, it can provide a glimpse of how we are working to speed up the claims adjudication process.

The Web Tool will provide two new features:

1. Claim Estimate: Providers will have the ability to submit a claim estimate and receive a response with payment assurance for the total payment (including payer payment and member liability amounts) for services. A claim estimate can be submitted up to 7 days prior to services performed and will be valid up to 7 days.
2. Claim Submission: Providers will have the ability to submit claims to Blue Shield of California and connect with Blue Shield's processing system for real time adjudication. The finalized claim/payment decision is then presented to the provider. Claims are then paid upon the regular payment cadence.

The Real Time Claims Web Tool is available to registered users on Provider Connection at blueshieldca.com/provider. If you are not a registered user, please see the section Welcome to Provider Connection on the home page of blueshieldca.com/provider for instructions on how to register.

Once you are registered on Provider Connection you will need to request access to the Real Time Claims Web Tool via your Account Manager, MSO, or Billing Service. After access is obtained for the Real Time Claims Web Tool it can be opened by clicking Claims on the menu bar then clicking Real Time Claims.

The Real Time Claims Web Tool is an intuitive system designed with provider ease of use in mind. A reference guide and FAQ documentation can be found on the Real Time Claims landing page under RTC Guidelines and Resources.

Future State

To further realize our long-term solution, Blue Shield is working on two other processes to make claims processing automated. These offerings will be coming throughout 2021 and will revolutionize how we as an industry process claims. The upcoming claims processing solutions are further defined below.

1. Utilization of direct system-to-system connection between providers and Blue Shield. This solution will give providers the opportunity to create claims within their own systems and submit them electronically in real time to Blue Shield.
2. Claims are automatically generated, eliminating all administrative burden from providers. This will be accomplished through a connection with the providers' Electronic Health Records (EHR) systems and claim is then sent to Blue Shield through a digital connection to be adjudicated in real-time.

***Added** the following new section:*

PERFORMANCE - REGULAR AND COMPLETE SUBMISSION OF ENCOUNTER DATA

Monthly Submission

It is Blue Shield's requirement that encounter data be submitted at least once each month and each submission must be in the correct HIPAA Compliant electronic format with usable data. Files with significant data quality problems may be rejected and may require correction of problems.

Complete Submission

Blue Shield will measure encounter submissions based on a rolling year of utilization data. The Centers for Medicare & Medicaid Services (CMS) requires EOBs for Medicare Advantage members with Medicare Part C. Providers are required to submit encounter submissions with Maximum Out-of-Pocket "MOOP" for Medicare Advantage members.

There is also a compliance measurement reflecting the data collection period. A benchmark using Evaluation and Management (E&M) CPT codes are used. The benchmarks is:

Medicare Advantage Membership: 8.0 E&M Visits PMPY

Certain types of denied services are included in calculating each provider's annual E&M visit rates.

Denials

All denied Medicare Advantage encounters should be submitted to Blue Shield, except for duplicate encounters and eligibility denials.

A provider contract may include an incentive program or capitation withhold provision that would apply for performance relative to the above benchmarks. The current performance target is at least 90% of the benchmark.

Blue Shield requires that, on a periodic basis, an officer of the provider group attest to the completeness and truthfulness of encounter data submission.

PROVIDER APPEALS OF MEDICARE ADVANTAGE CLAIMS

*This section has been **deleted and replaced** with the following language:*

Non-Contracted

CMS requires Medicare Advantage Organizations (MAOs) to apply the provider dispute resolution process for payment disputes between non-contracted and deemed providers. Non-contracted and deemed providers are defined as follows:

- A non-contracted provider is one that was not aware the patient was a private fee-for-service member at the time of service, e.g., an emergency situation.
- A deemed provider is one who was aware that the patient was a private fee-for-service member at the time of service, and therefore had the ability to view the plan's terms and conditions of payment.

  Note: The provider dispute resolution process for payment disputes between non-contracted and deemed providers does not include Part D claims.

PROVIDER APPEALS OF MEDICARE ADVANTAGE CLAIMS *(cont'd.)*

Provider disputes include any decisions where a non-contracted/deemed provider contends that the amount paid by the organization (MAO and/or delegated entity) for a covered service is less than the amount that would have been paid under original Medicare. The disputes may also include instances where there is a disagreement between a non-contracted/deemed provider and the organization about the plan and/or delegated entity's decision to pay for a different service than that billed. An example would include down-coding.

A provider or supplier has the right to dispute a reimbursement decision made by a MAO Plan and/or delegated entity. The time frame for disputing a reimbursement issue to the MAO Plan and/or delegated entity is 120 calendar days from the initial determination date for all non-contracted, underpayments. The provider has 60 calendar day from initial determination date for all non-contract zero payment claims. These appeals should be accompanied by a waiver of liability (WOL).

If the required information to process the dispute has not been submitted, Blue Shield will send a letter to the provider requesting the necessary documentation. If the additional documentation is not received within 60 calendar days from the date of request, Blue Shield will conduct a review based on what is available.

Blue Shield will resolve the dispute within 60 calendar days of the receipt of the dispute. In the event that the additional payment is warranted in favor of the provider and was due to an error by Blue Shield, interest will be included along with the additional payment.

After the MAO Plan and/or delegated entity makes its Payment Review Determination (PRD) decision, if a deemed or non-contracted provider or supplier still disagrees with the pricing decision of a MAO Plan and/or delegated entity, the provider has the right to contact Medicare at 1-800-Medicare for a 2nd level review.

Section 5: Blue Shield Benefit Plans and Programs

BLUE SHIELD MEDICARE ADVANTAGE PLANS

This subsection regarding enrollment eligibility for members with End Stage Renal Disease (ESRD) has been ***deleted and replaced*** *with the following language:*

On May 22, 2020, CMS issued a Final Rule that permits enrollment of individuals with End Stage Renal Disease (ESRD) in MA-PD plans, effective January 1, 2021, as long as they meet the Medicare Advantage carriers' eligibility criteria.

BLUE SHIELD MEDICARE (PPO) (MEDICARE ADVANTAGE)

Non-Formulary Outpatient Prescription Drugs

Added *the following language to the* Transition Policy *section:*

To request a Formulary Exception (a type of Coverage Determination), Prescribers should submit persuasive evidence in the form of studies, records, or documents to support the existence of the situations listed above via a prior authorization request.

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to request a prior authorization or exception request by faxing a Medicare Coverage Determination Request Form (available at blueshieldca.com/provider) to (888) 697-8122 or via phone to (800) 535-9481 Monday through Friday, 8:00 a.m. until 6:00 p.m. PST, excluding holidays.

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the Authorizations section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate Medicare Coverage Determination Request Form, as the required information is built into the tool.

Vision Services

Updated *provider who delivers vision services for individual plans to VSP Vision Care.*

Exclusions to the Blue Shield Medicare (PPO) Benefits

Updated *the following plan exclusion in boldface type below:*

- Routine acupuncture, **except for chronic low back pain**, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.

Prescription Drug Benefit Exclusions

Updated *the following plan exclusion in strike through and boldface type below:*

- ~~Drugs when used to promote fertility~~ **Drugs related to assisted reproductive technology (ART)**

MENTAL HEALTH SERVICES – PSYCHIATRIC CARE

This section has been ***deleted and replaced*** *with the following language:*

The diagnosis and medically necessary treatment of mental health disorders listed in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* are covered benefits for all Blue Shield plans. Blue Shield's mental health service administrator (MHSA) for commercial PPO members is Human Affairs International of California (HAI-CA).

Members must utilize the Blue Shield MHSA provider network to access psychiatric covered services. The MHSA participating provider must obtain prior authorization from the MHSA for all non-emergency mental health and substance use disorder inpatient admissions including residential care, and other outpatient mental health and substance use disorder services.

Commercial PPO members should use the Member Self-Referral phone number below to contact Blue Shield's MHSA to access behavioral health care.

Appendices

Added *the following appendices which detail the file formats for electronic eligibility reports.*

APPENDIX 1-B BLUE SHIELD COMBINED ELIGIBILITY/CAPITATION REPORT

APPENDIX 1-C BLUE SHIELD HMO ELIGIBILITY ADDS AND TERMINATIONS REPORT

APPENDIX 2-A BLUE SHIELD BYLAWS

This appendix has been ***deleted and replaced*** *with revised bylaws dated August 16, 2019.*

APPENDIX 2-C NCP GUIDELINES FOR PALLIATIVE CARE

This appendix has been ***deleted*** *and* ***replaced*** *with Domain 1: Structure and Processes of Care, Guideline 1.2 Criteria from the* National Consensus Project Clinical Practice Guidelines for Quality Palliative Care *guidelines.*

APPENDIX 4-A SPECIAL BILLING GUIDELINES AND PROCEDURES

Deleted *the CMS 1500 claim form instructions from this document and* ***added*** *them in Appendix 4-D. Special billing guidelines for the CMS 1500 remain in this appendix.*

Added *the following section to the appendix. These guidelines were previously in Appendix 4-E.*

Guidelines for Successful OCR Processing

Added *the following section:*

Nurse Practitioner and Physician Assistant

Claims submitted for these services should include the Name and NPI of the Nurse Practitioner or Physician Assistant as the rendering provider (Loop 2310 B) and the Supervising Physician Name and NPI referenced in the 2310D Loop.

Drug Requirements - 837 Professional Claims

Updated *the following section:*

Home infusion services and office administered drug claims that do not have a medical record attached are required to be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

For billing purposes, National Drug Codes (NDCs) contain 11 digits in a fixed 5-4-2 configuration. The NDC is usually found on the drug label. Do not use submit the NDC from the outer packaging of a box containing multiple vials or doses. If the NDC on a product does not contain 11 digits, leading zeros should be added to fill in the missing number(s) to maintain the 5-4-2 format.

Example for billing purposes when the NDC has fewer than 11 digits:

- NDC On Product: 345-1234-2 (NDC has only 8 digits but 11 digits are required)
- NDC For Billing: 00345-1234-02 (Leading zeros are added to conform with the 5-4-2 configuration)

HEDIS® Guidelines

Updated *the HEDIS measurement charts to provide detailed descriptions of services.*

APPENDIX 4-D CMS 1500 GENERAL INSTRUCTIONS

*Instructions have been **updated** to align with CMS guidelines.*

APPENDIX 4-E GUIDELINES FOR SUCCESSFUL ICR PROCESSING

***Deleted** this appendix. These guidelines have been added to Appendix 4-A.*

APPENDIX 4-F WHERE TO SEND CLAIMS

***Renamed** to Appendix 4-E Where to Send Claims.*

***Updated** claims addresses. For the most current list, go to Provider Connection at blueshieldca.com/provider and click on* Claims, How to submit claims, *then* Claims mailing addresses *under* Submitting Claims by mail.

APPENDIX 4-G BLUE SHIELD PAYMENT PROCESSING LOGIC

***Renamed** to Appendix 4-F Blue Shield Payment Processing Logic.*

APPENDIX 4-H LIST OF OFFICE-BASED AMBULATORY PROCEDURES

***Renamed** to Appendix 4-G List of Office-Based Ambulatory Procedures.*

***Added/updated** the following procedure codes:*

20560	Ndl insert w/o inj 1 or 2 muscles
20561	Ndl insert w/o inj 3 or more muscles
64454	Inj Aa&/Strd Genicular nrv brnch
64624	Dest Neurolytic agt Genicular nrv
0551T	Tprnl balo cntnc dev adjmt
0563T	Evac Meibomian gld heat bilat
0566T	Autol cell impt adps tiss njx imp knee
0588T	Rev or rem isdns post tibial nrv

***Deleted** the following procedure codes:*

0380T	Comp animat ret image series
0482T	Absolute quant myocardial bld flow

APPENDIX 5-A THE BLUECARD PROGRAM

Products Included in the BlueCard Program

Added *the Blue High Performance Network℠ (HPN℠) plan to Exclusive Provider Organization (EPO) product line.*

How to Identify Members

Added *language about identifiers on the Blue HPN EPO ID card, as follows:*

- An HPN in a suitcase logo with the Blue High Performance Network name in the upper right or lower left corner, for Blue HPN EPO members.

The Blue HPN EPO product includes an HPN in a suitcase logo on the ID card. Members must obtain services from Blue HPN providers to receive full benefits. If you are a Blue HPN provider, you will be reimbursed for covered services in accordance with your contract with Blue Shield of California. If you are not a Blue HPN provider, it is important to note that benefits for services incurred with non-Blue HPN providers are limited to emergent care within Blue HPN product areas, and to urgent and emergent care outside of Blue HPN product areas. For these limited benefits, if you are a PPO provider, you will be reimbursed according to Blue Shield of California PPO provider contract, just as you are for other EPO products.

How to Identify Blue plan HPN Members

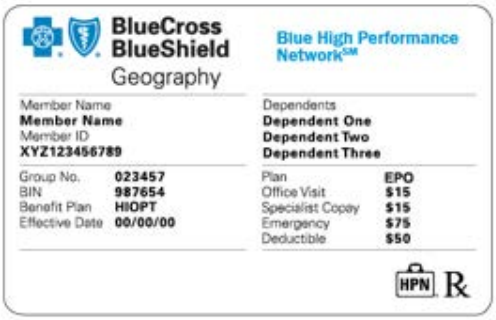
Added *language about identifying a Blue HPN member, including a sample ID card, as follows:*

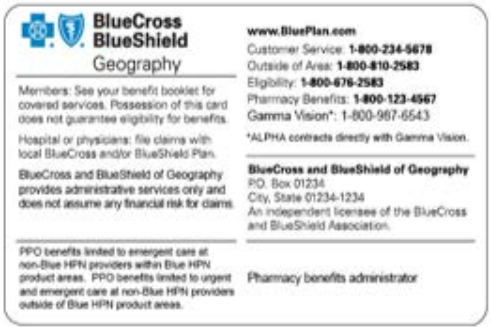
The Blue High Performance Network is a new network that is available to members who live in key metropolitan areas. Blue HPN members must access Blue HPN providers in order to receive full benefits. If you are a Blue HPN provider, you will be reimbursed for services provided to Blue HPN members according to your contract with Blue Shield of California. If you are not a Blue HPN provider, it is important to note that benefits for services incurred with non-Blue HPN providers are limited to emergent care within Blue HPN product areas, and to urgent and emergent care outside of Blue HPN product areas.

You can recognize Blue HPN members by the following:

- The Blue High Performance Network name on the front of the member ID card
- The HPN in a suitcase logo in the bottom right hand corner of the member ID card

Language regarding benefit limitations is also included on the back of the Blue HPN EPO member ID card. For these limited benefits, if you are not a Blue HPN provider but are a PPO provider, you will be reimbursed according to Blue Shield of California PPO provider contract, just like you are for other EPO products.





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

Submitting BlueCard Claims

Added *language describing the claims re-routing process should a claim be routed to the wrong processor, as follows:*

Other state independent licensee(s) of the Blue Cross Blue Shield Association may select Blue Shield of California or another licensee of the Blue Cross Blue Shield Association in the State of California as the preferred processor of their BlueCard claims in California for particular accounts, groups, procedures and/or other circumstances. Submitting claims to the wrong processor or payor can cause substantial delays in processing. Blue Shield and its agents will provide best efforts to review claims submitted to California processor(s). In the event a claim is submitted to a non-preferred processor, Blue Shield may re-route claims as needed. Re-routing of BlueCard claims may occur in accordance to Blue Shield's agreement(s) with another licensee of the Blue Cross Blue Shield Association. Where other state independent licensee(s) of the Blue Cross Blue Shield Association has selected another independent Blue Cross and Blue Shield licensee in California, as their processor for accounts or groups, Blue Shield will provide best effort to re-route claims to that licensee. This claim review process is integral to our claims processing and claims routing systems and cannot be selectively enabled by Provider. While Blue Shield and its agents will provide best efforts; we cannot ensure that 100% of all claims are reviewed prior to Payor delivery. Blue Shield is not responsible for any delays or liability from the provision or non-provision of this service or subsequent re-routing or non-re-routing.

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.