601 12th Street
Oakland, CA 94607

October 13, 2023

Subject: **Notification of January 2024 updates to the Blue Shield *HMO IPA/Medical Group Procedures Manual***

Dear IPA/medical group:

Blue Shield is revising the *HMO IPA/Medical Group Procedures Manual* (Manual). The changes in each provider manual section listed below are effective January 1, 2024.

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 PDF version of the revised *HMO IPA/Medical Group Procedures Manual* be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *HMO IPA/Medical Group Procedures Manual* is included by reference in the agreement between Blue Shield of California (Blue Shield) and those IPAs and medical groups contracted with Blue Shield. If a conflict arises between the *HMO IPA/Medical Group Procedures Manual* and the agreement held by the IPA or medical group and Blue Shield, the agreement prevails.

If you have any questions regarding this notice or about the revisions to be published in the January 2024 version of this Manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

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.

Section 2.4: Blue Shield Added Advantage POS Plan

Claims Submission

Added the following new section on Corrected Claims:

Corrected Claims

Once the initial claim has finalized in our system, resubmit the corrected claim with the appropriate adjustment bill type. Corrected claims should be submitted within 365 days from the claim finalized date unless otherwise specified in the contract.

Section 2.8: Benefits and Benefit Programs

Additional Care Management Program Descriptions

Changed the Landmark Home-Based Care program name to Home-Based Complex Care.

Drug Formulary

Added the following language regarding prior authorization:

Prescribers must submit prior authorization to Blue Shield for prescription medications before medications are dispensed. Prior authorizations submitted by an unauthorized source, including but not limited to pharmacies, will be dismissed and a request sent directly to the prescriber's office for prior authorization.

Pharmaceuticals in the Medical Benefit

Added an example of a high-cost medication that is subject to Blue Shield review for coverage in boldface type below:

Ultra high-cost medications including CAR-T and Gene Therapy **or drugs costing over $100,000 per single dose** are subject to Blue Shield review for coverage according to Blue Shield Medication Policy regardless of if utilization management is delegated to the IPA/medical group. Refer to Section 5.1: Prior Authorization.

Section 4.1: Network Administration

Practitioner Credentialing

Added "American Osteopathic Association (AOA)" to lists of agencies that potential practitioners be board-certified by to be included in the Blue Shield HMO network.

Added new sections for credentialing of nurse practitioners and Mental Health/Substance Use Disorder providers.

Specialty Credentialing Specifications

Nurse Practitioners (NP)

Assembly Bill 890 (AB 890) grants nurse practitioners full practice authority allowing them to work without physician supervision. To practice in an integrated setting, NPs must hold national certification and carry liability insurance. If an NP is interested in solo practice, completion of a three (3) year transition to practice will be required as well.

AB 890 allows NPs to practice to the full extent of their education and training and allow direct access to health care for millions of Californians who now have coverage, but often struggle to find healthcare providers. A nurse practitioner shall verbally inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase "enfermera especializada." A nurse practitioner shall post a notice in a conspicuous location accessible to public view that the nurse practitioner is regulated by the Board of Registered Nursing. The notice shall include the board's telephone number and internet website where the nurse practitioner's license may be checked and complaints against the nurse practitioner may be made.

Mental Health and Substance Use Disorder Providers

Assembly Bill 2581 (AB 2581) requires the following procedures be put in place for Mental Health/Substance Use Disorder providers, effective January 1, 2023:

- All Mental Health/Substance Use Disorder providers, upon receipt of a completed application, will receive an application received letter within seven days to verify receipt and inform the applicant whether the application is complete.
- All complete Mental Health/Substance Use Disorder provider applications for credentialing will be completed within sixty (60) days.

Provider Status Changes

Termination of Providers

Added the following new sections to align with language in the provider agreements.

Automatic Termination of Providers

Blue Shield shall require a contracting IPA/medical group to immediately terminate any provider, the effect of which is to immediately prohibit the provider from treating members, upon the occurrence of any of the following events, and such termination shall not give rise to any procedural rights under Blue Shield's Fair Hearing policy:

- A provider's suspension or revocation of licensure as a physician in California or for disciplinary cause in any other state, whether or not stayed or subject to probation;
- A provider's failure to maintain a valid and unrestricted license;
- A provider's conviction of a felony or criminal offense relating to practice or fitness as a physician, fraud, or moral turpitude;
- An action taken by any federal or state agency administering a program providing health benefits that terminates or restricts the provider's right to participate in such program for reasons related to the provider's professional competence or conduct.

Suspension, Restriction, and/or Termination of Providers

The following events constitute grounds for suspension, restriction and/or termination of a provider by Blue Shield. Except as otherwise specified in this Provider Manual, Blue Shield's suspension, restriction, and/or termination of any provider's right to treat members entitles the provider to the procedural rights set forth in Blue Shield's Fair Hearing policy if the action is taken for medical disciplinary cause or reason and if the final imposition of the action require Blue Shield to report its action to the appropriate licensing board under Business and Professions Code Section 805 or to the National Practitioner Data Bank.

- A provider's diagnosis, including a good faith belief that the provider has been diagnosed, as suffering from a severe mental or emotional disturbance that detrimentally affects the provider's ability to provide services in a manner consistent with generally accepted professional standards;
- A provider's professional incompetence, including a good faith belief in the provider's professional incompetence, non-cooperation with this Provider Manual, or non-performance of professional responsibilities;
- A provider's addiction, including a good faith belief in the provider's addiction, to alcohol, narcotics, or other drugs or physical disability that impairs the provider's ability to practice their profession in a competent manner;
- A provider's failure to provide satisfactory personal or professional references and credentials, or to provide verifiable information regarding past employment, training, hospital affiliation or professional licensing;
- A provider being a party to malpractice or other litigation or arbitration that has resulted in one or more substantial judgments, settlements, or awards against the provider; and
- A provider's conduct, including a good faith belief that the provider has engaged in conduct that is inappropriate, unprofessional, and/or violates state or federal law, or that constitutes good cause for suspension, restriction, or termination of the provider's participation in Blue Shield HMO provider networks.

Language Assistance for Persons with Limited English Proficiency (LEP)

Updated this section to include the following NCQA requirements:

- Demographic language services information including membership thresholds
- Cultural awareness and linguistic information, online resources, and training materials
- Language assistance resources for translation and interpretation services
- Multilingual online resources

Section 4.4: Claims Administration

Performance - Regular and Complete Submission of Encounter Data

Complete Submission

Added language regarding the Electronic Monthly Submission Process and additional benchmarks, as follows:

The completeness of encounter data is required by regulatory bodies, including CMS and DHCS. In order to ensure data is being received through the Electronic Monthly Submission Process, providers will participate in a reconciliation process as requested by Blue Shield to ensure data is complete and accurate. The format of the data to be sent is provided at the time of reconciliation request. Blue Shield may use 837 data as basis for Evaluation and Management (E&M) calculations.

For Medicare Advantage encounter data submissions to CMS, there is also a compliance measurement reflecting the data collection period. Benchmarks using E&M CPT codes are used. The benchmarks are:

Commercial Membership:

- 3.0 E&M Visits PMPY
- 35% of members have an E&M visit within 120 days of enrollment
- 65% of existing members have an E&M visit annually

Medicare Advantage Membership:

- 8.0 E&M Visits PMPY
- 85% of members have an E&M visit within 120 days of enrollment
- 95% of existing members have an E&M visit annually

Certain types of denied services are included in calculating each IPA/medical group's annual E&M visit rates. See Appendix 4-D for a list of E&M codes.

Section 4.5: Provider Appeals and Dispute Resolution

Provider Appeals and Dispute Resolution

Updates made throughout section to clarify that commercial appeals can be submitted electronically or on paper. Blue Shield will acknowledge paper appeals within 15 working days and electronic submissions within 2 working days. For additional information regarding the appeal process, and to review digital submission options, please visit Provider Connection at blueshieldca.com/provider.

Provider Appeals of Medicare Advantage Claims

Non-Contracted Providers

Revised the following language to clarify the dispute process for non-contracted providers:

A provider or supplier has the right to dispute a reimbursement decision made by a MAO Plan. A provider has the right to request a reconsideration of the denial of payment within 60 calendar days for $0 payments and 120 calendar days for underpayments after the receipt of notice of initial determination/decision.

Providers who wish to submit an appeal must also submit a signed Waiver of Liability (WOL) statement holding the member harmless regardless of the outcome of the appeal. Providers should include documentation such as a copy of the original claim, remittance notification showing the denial and any clinical records and other documentation that supports the provider's argument for reimbursement. If there is no WOL submitted, the plan will make three attempts to request the WOL. If the WOL is not submitted after 3 attempts and before the 60th calendar day, the plan may dismiss the provider appeal.

After the MAO Plan makes its Payment Review Determination (PRD) decision, all Medicare non-contracted zero payment denials are auto forwarded to the Independent Review Entity (IRE). For non-contracted Medicare/CMC underpayments, providers can contact 1-800-Medicare. For cases that are dismissed, the provider has the right within 180 days to ask the plan to vacate (set aside) the dismissal action if the plan determines there is good cause to vacate. The provider also has the right to ask for an independent reviewer contracted with Medicare to review the decision to dismiss the appeal request within 60 calendar days to Maximus Federal Services, Inc.

For additional information regarding the appeal process, and to review digital submission options that will be available to Medicare providers in December 2023, please visit Provider Connection at blueshieldca.com/provider.

Section 5.1: Utilization Management

Blue Shield Medical and Medication Policies

Medication Policy

Added "consensus guidelines" to the list of standards that the Pharmacy and Therapeutics (P&T) Committee uses for clinical decision-making.

Delegation

Delegation of Utilization Management

Added 'Withdrawals/Dismissals with Medical Records' to the activities that are monitored and reviewed for the delegated entity throughout the year.

Delegation Oversight

Updated the email for the Delegation Oversight Department to: BSCPHP_UMDelegationOversight@BlueShieldca.com.

Prior Authorization

Updated the description of IV infusion or injectable therapy requiring prior authorization to include Hemophilia Factor Products, Hemlibra, and ultra high-cost drugs such as CAR-T, Gene Therapy, or drugs costing more than $100,000 per single dose.

Section 5.2: Quality Management Programs

Medical Record Review

Access to Records

Added language regarding medical records, as follows:

The IPA/medical group shall provide all such records at no charge to Blue Shield upon request. Accordingly, if the IPA/medical group or its selected copy-vendor invoices Blue Shield and Blue Shield pays the vendor to expedite the process, Blue Shield has the right to collect such charged fees from the IPA/medical group.

Delegation of Credentialing

Credentialing Oversight

Updated reporting requirements for Oversight of Credentialing System Controls.

Added new sections for credentialing of Nurse Practitioners and Mental Health/Substance Use Disorder providers. See Section 4.1 above for language.

Service Accessibility Standards

Behavioral Health Appointment Access Standards

Added access standard for initial routine visits, as follows:

Initial routine visits with non-physician practitioners and behavioral health physicians	Within 10 business days

Section 6.1: Blue Shield Medicare Advantage Plan Program Overview

Blue Shield Medicare Advantage Plan Service Areas

Removed the following counties from the **Individual** and **Group** Service Area charts:

Fresno, Madera, Sacramento, and Ventura.

Removed Fresno county from the Dual Eligible Special Needs Plan Service Area chart.

Blue Shield Medicare Advantage Plan Provider Network

Medicare Part D Prescriber Preclusion List

Added the following to the Medicare Part D Prescriber Preclusion List criteria:

(c) Have been convicted of a felony under federal or state law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program.

Section 6.2: Blue Shield Medicare Advantage Plan Benefits and Exclusions

Medication Therapy Management Program (MTMP)

Updated information about the Medication Therapy Management Program (MTMP)in strikethrough and boldface type below:

Blue Shield provides a Medication Therapy Management Program (MTMP) for its Medicare Part D members to assist them in managing their chronic conditions. The Blue Shield MTMP is for members meeting all of the following criteria:

- Have **two** of the following conditions:
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Hypertension
  - Osteoporosis
  - ~~Respiratory Disease~~ **Chronic Obstructive Pulmonary Disease (COPD)**
- Receive **seven** or more different covered Part D maintenance medications monthly
- Likely to incur an annual cost threshold established by CMS each calendar year for Medicare covered prescriptions

Blue Shield Medicare Advantage Plan Benefits

Vision Services and Hearing Services

Removed language regard prior auth for D-SNP members as they are not required to obtain prior authorization for routine vision or hearing services.

Appendix 4-A: Claims, Compliance Program, IT System Security, and Oversight Monitoring

Key Terms and Definitions

Contested Claims - Commercial

Added the following language to this section:

Delegated Entity will be audited against and must maintain compliance with Claims Settlement Practices in accordance with Title 28 Section 1300.71 (a)(8)(H) and (I) contesting claims for Medical Records.

(H) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to a plan or a plan's capitated provider by all providers over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with the section (a)(2). The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices.

(I) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the plan's or the plan's capitated providers for emergency room service and care over any 12-month period was reasonably necessary to

determine payor liability for those claims consistent with section (a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices.

Acknowledgement of Receipt

Deleted *and* ***replaced*** Commercial section with the following:

The Delegated Entity must acknowledge receiving electronic claims within two (2) working days of date of receipt of the claim and paper claims within 15 working days of date of receipt of the claim.

Acknowledgement timeframes are based on the date of receipt. The acknowledgment date for electronic submission claims should be either the date the claim became available to the Delegated Entity from their clearing house or the date the claim arrived directly via direct electronic delivery.

Acknowledgement must be in the same manner as the claim was submitted or provided by electronic means, by phone, website, or another mutually agreed upon accessible method of notification. (CCR Title 28 Section 1300.71(c)).

Blue Shield will validate Delegated Entity/MSO website to assure that directions are provided for a non-contracted provider regarding how they can confirm receipt of claim.

Added the following sections on submitting EOP/RAs:

Commercial Evidence of Payment (EOP)/Remittance Advice (RA)

Each Delegated Entity needs to include the following information in their EOP/RA:

- PDR Verbiage

  California Code of Regulations, Title 28 Section 1300.71.38 (b)
  - (b) Notice to Provider of Dispute Resolution Mechanism(s). Whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address for a filing a provider dispute.
  - The right to dispute a claim using the approved PDR request form.
  - The dispute must be submitted within 365 calendar days from last claim action.
  - Written determination of the dispute must be made consistent with applicable state and federal law, within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
  - A provider has the right to submit an appeal if they do not agree with this resolution of this claims dispute. The language should include "you have the right to appeal directly to Blue Shield of California within 60 working days from the Date of Determination." This appeal would only be for Medical Necessity *de novo* review.

Medicare Evidence of Payment (EOP)/Remittance Advice (RA)

Each Delegated Entity needs to include the following information in their EOP/RA:

- Denial Rights
- Waiver of Liability Statement
  - The Waiver of Liability statement can be downloaded from the CMS website at https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip
  - Per CMS, Delegated Entities cannot provide a link to the CMS web page and give the non-contracted provider the instructions to access the form
  - The EOP should have the waiver of liability link referenced above OR
  - Waiver of Liability link and form together

    Note: Delegated Entities CANNOT have the form only.
- Appeal Rights
- PDR Second Level Verbiage
  - "You have the right to dispute this decision directly with Blue Shield of California within 180 days from the determination of the payer."

Member Denial Notice – Standards (Commercial)

Added the following language:

All member emergency and non-emergency denial letters must include the denial code and denial reason. The denial reason code should match what is being submitted on the EOB/RA.

Best Practices and Claims Adjudication

Audits and Audit Preparation

Deleted and ***replaced*** language detailing the audit preparation process, as follows:

Blue Shield, CMS, and the DMHC will conduct periodic audits of claims and provider disputes (where appropriate) to ensure compliance with all regulatory requirements. In advance of Blue Shield's audit, Blue Shield will send a written notification 60 days prior to the audit that includes the documents the Delegated Entity will need to provide along with the scope of the audit and due dates of when the material needs to be submitted. The documentation includes providing claims universes for each category. An industry standard questionnaire will need to be completed that will provide detailed information about your claims processing operations and internal controls. Also provided is a cover sheet that needs to be completed and attached to each claim sample. Note that the claim sample must include the following documentation from the contract with the provider: the first and last page (signature) and rate sheet. All documentation is required to be submitted with the sample claim as noted on the cover sheet.

Blue Shield will perform an annual audit for claims and compliance oversight which include internal controls and IT system security. Blue Shield will provide a notification of the annual audit that includes the scope of the audit along with interviews of appropriate departments within the Delegated Entity's organization. Blue Shield will require a walk through and demonstration of the Delegated Entity's operations. This will include a demonstration of the life

of a claim from end to end (mailroom to disposition of payment and/or denial) which will include operational systems and interviews with staff associated with specific functional areas. To assure end to end processes are formally documented Blue Shield requires submission of Policy and Procedures (P&P) noted in the industry standard questionnaire as well as P&Ps requested during the audit claims assessment questions interview on the scheduled audit day. As part of the assessment, Blue Shield evaluates that P&Ps are reviewed annually via evidence that they were approved via committee or appropriate authority signature and dated.

If required claims documentation is not received, the audit is incomplete and will be scored as non-compliant and a corrective action plan (CAP) will be required by the Delegated Entity along with a follow up audit that will be scheduled. The Delegated Entity will be escalated to the Delegation Oversight Committee as non-compliant for lack of submission of audit documents. Electronic submission of all data is required.

Blue Shield will provide the Delegated Entity with written results within 30 days including an itemization of any deficiencies and whether or not the Delegated Entity must prepare and submit a formal, written corrective action plan to include root cause and remediation within 30 days of receipt of audit results or provide additional supporting documentation within time period provided by Blue Shield.

Updated language detailing the process for date-stamping paper claims, in boldface type below:

Date Stamping

Delegated Entities must date stamp all paper claims, including facsimiles, with the date the claim was received. The stamp should identify the specific Delegated Entity. Blue Shield recommends that each page of the paper claim including any attachments be date stamped. **If a paper claim is received and then scanned for audit purposes, it should be batched for scanning by the original received date and include a unique identifier of the received date on the image.**

Corrective Action/Follow Up Audits

Added the following sub-section concerning the annual claims and PDR audit:

Blue Shield performs, at a minimum, an annual claims and PDR audit. Follow-up audits will be scheduled by the assigned auditor if the Delegated Entity fails the annual audit. If applicable, as a result of a non-compliant follow-up audit, additional monitoring and/or remediation validation audits will be performed based upon outcome of escalation to the Delegation Oversight Committee. For those Delegated Entities who are subject to DMHC audits, if deficiencies are determined during the review, a corrective action plan (CAP) is required to be sent to Blue Shield by the date provided by the auditor. Additionally, Blue Shield may perform an unannounced audit dependent upon other indicators.

Compliance Program Effectiveness Oversight Audit

Changed name of sub-section from "Compliance Program/Fraud, Waste, and Abuse" to "Compliance Program Effectiveness Oversight Audit."

Deleted and replaced with the following language:

Delegation Oversight will perform an annual audit of the effectiveness of your organization's Compliance Program. The audit includes the assessment of the following:

- Compliance Program structure (the effectiveness of your organization's compliance program.
- Risk Bearing Organization (RBO) and Management Services Organization (MSO) ownership and hours of availability.
- Training material and the training your organization conducts for all employees (including temporary and contracted employees).
- Implemented policies and procedures.
- FWA reporting.
- Monitoring and auditing internal risks.
- Organization's internal controls and organization capacity structure.

This audit will be performed either via Blue Shield Delegation Oversight Compliance Team individually on an annual basis or as a shared audit through HICE (Health Industry Collaborative Effort).

The Compliance audit evidence grid will be provided by the Delegation Oversight Auditor prior to the scheduled audit date. The grid should be used as a guide for audit documentation submission guidelines and as well as policy and business rules to assist with understanding the audit history and requirements. To download a copy of the Compliance Audit Evidence Grid, go to the Blue Shield provider website at www.blueshieldca.com/en/bsp/providers and navigate to the *Forms* section, then *Delegation oversight forms*. All requested documents from the evidence grid must be submitted to BSCandPHP_DOCPEAudit@blueshieldca.com.

For more information on the shared audit process and joining, please visit the HICE website at www.iceforhealth.org/teamactivities.asp.

Claims Delegate Reporting Instructions

Changed the due date of the quarterly Organization Determinations, Appeals, and Grievances (ODAG) Report to the 15th of each quarter (April 15, July 15, October 15, and January 15).

Appendix 4-C: Actuarial Cost Model

Updated the model with 2024 data.

Appendix 4-D: Evaluation and Management (E&M) Codes

Added a new appendix that lists procedure and revenue codes that are used to calculate the number of E&M visits.

Appendix 5-B: Credentialing/Recredentialing Standards

Updated to align with current Blue Shield policies and procedures, delegation agreements, as well as the delegation oversight process.