601 12th Street
Oakland, CA 94607

January 20, 2023

Subject: **Notification of January 1, 2023 Updates to the Blue Shield *HMO IPA/Medical Group Procedures Manual***

Dear IPA/medical group:

We have revised our *HMO IPA/Medical Group Procedures Manual* to include D-SNP policy changes as issued by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC). The changes listed in the following provider manual sections are effective January 1, 2023.

Beginning on January 20th, 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 by emailing providermanuals@blueshieldca.com.

The *HMO IPA/Medical Group Procedures Manual* is referenced 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 about the revisions that will be published in the January 1, 2023 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

Updates to the *HMO IPA/Medical Group Procedures Manual*

Section 5.1: Utilization Management

Added language throughout section noting where Prior Authorization lists are located on the Provider Portals for D-SNP Medicare and Medi-Cal members, as follows:

For D-SNP members, please refer to Blue Shield's Medicare Prior Authorization List located on Provider Connection at blueshieldca.com/provider under *Authorizations, Prior authorization forms and list,* then *Prior authorization list for Blue Shield*, for services that require prior authorization under Medicare. View the Blue Shield of California Promise Health Plan (Blue Shield Promise) Medi-Cal Prior Authorization List at blueshieldca.com/promise/providers under *Clinical policies, procedures and guidelines,* then *View prior authorization list* for services that require prior authorization under Medi-Cal. The lists are updated monthly.

UM Criteria and Guidelines

Added the following language:

For D-SNP members, for services that require a prior authorization, new CMS, DHCS and DMHC guidelines will require shared and full-risk IPAs to ensure their internal processes support the new regulation. This means that some IPAs will need to work with Blue Shield and Blue Shield Promise somewhat differently.

UM Authorization Reporting Process

Approval/Denial Data File Requirements

Deleted and ***replaced*** with the following language:

Approval/denial data files ("Authorization Logs") must be delivered via secure email or Secure File Transfer Protocol (SFTP) file to Blue Shield using either the IPA9 or IPA10 file layout. To initiate the delivery of authorization logs by means of a SFTP or to obtain the IPA9 or IPA10 Blue Shield standard file layout and data dictionary, please email Medicare Care Solutions at IPAAuths@blueshieldca.com.

Only shared-risk services for which the IPA/medical group is delegated to perform UM and Blue Shield is responsible for claim adjudication are required on the data file.

Authorization logs must be sent to Blue Shield, at minimum, on a weekly basis in order to ensure timely data processing. IPA approvals, denials and partial denials should be delivered together on one file. If sent via email, the data MUST be delivered in a file format that is suitable for data processing such as an Excel spreadsheet or delimited fixed width file. **Please note:** Any data file which does not comply to the format, content requirements and/or delivery frequency will be considered out of compliance, rejected by Blue Shield, and returned to the IPA/medical group for correction and resubmission.

Hospital	Please submit Authorization Log to Blue Shield either immediately prior to, or at the time of a hospital admission, discharge, or transfer for all Blue Shield Dual Special Needs Plan (D-SNP) members.	
SNF	Please submit Authorization Log to Blue Shield, if possible, within 48 hours of a SNF admission for all Blue Shield Dual Special Needs Plan (D-SNP) members.	Please submit Authorization Log to Blue Shield, if possible, in advance or at time of a member's SNF discharge or transfer for all Blue Shield Dual Special Needs Plan (D-SNP) members.

The following information is required on the Authorization Log. Please do not modify (add or subtract) any of these data elements from the Authorization Log.

- Subscriber ID #
- Patient Last Name
- Patient First Name
- Patient Date of Birth (mm/dd/yyyy)
- Health Plan/Line of Business (CMC, Medi-Cal, Medicare Advantage or Commercial)
- Request Type (Inpatient, Service or Medication)
- Place of Service (Using CMS Industry Standard Place of Service Code Set and/or Name/Description: POS 11/Office, POS 21/Inpatient Hospital, POS 31/Skilled Nursing Facility)
- Admission Bed Type or Level of Care (Using industry standard descriptions: Acute Rehabilitation, Acute Behavioral Health, ICU, LTAC, Med Surg, NICU, NICU Level 1, Observation, SNF Level 1, Sub-Acute, etc.)
- First date of service or Admit date (mm/dd/yyyy)
- Last date of service or Discharge date (mm/dd/yyyy)
- Diagnosis Code(s) (ICD-10-CM Codes) – Primary code and up to 3 additional codes, if applicable
- Procedure Code(s) (CPT-4/HCPC Codes and for inpatient facility claims only ICD-10-PCS Codes) – Primary code and up to 13 additional codes, if applicable
- Units: Number of procedures, treatments, , days, sessions, or visits
- Servicing Provider Name
- Servicing Provider NPI #
- Facility Name (if applicable)
- Facility NPI # (if applicable)
- Requesting Provider Name
- Requesting Provider NPI #
- Authorization or Decision Reference #
- Blue Shield IPA/Medical Group Provider Identification # (i.e., IPxxxxxxxxxx) – It is highly recommended to include your Blue Shield PIN # to expedite processing. If unknown, the PIN # can be obtained from your Blue Shield Provider Relations representative.
- Receipt Request Date (Date provider requested authorization from IPA/medical group)
- Decision (Approved, denied, partially denied or void)
- Full/Partial Denial Reason (i.e., Not medically necessary, not a benefit, etc.)
- Decision Date (mm/dd/yyyy)
- Discharge Diagnosis (if applicable)
- Discharge Status (i.e., To Home, SNF…., if applicable)

PKU-Related Formulas and Special Food Products

Added the following new section:

For Blue Shield Medicare Advantage Plan Members

For D-SNP Participants, Blue Shield of California and their delegates will consider both Medicare and Medi-Cal coverage criteria as an integrated organization determination. Please see Prior Authorization Lists below to determine if PKU Services require Prior Authorization.

For D-SNP members, please refer to Blue Shield's Medicare Prior Authorization List located on Provider Connection at blueshieldca.com/provider under *Authorizations, Prior authorization forms and list,* then *Prior authorization list for Blue Shield*, for services that require prior authorization under Medicare. View the Blue Shield of California Promise Health Plan (Blue Shield Promise) Medi-Cal Prior Authorization List at blueshieldca.com/promise/providers under *Clinical policies, procedures and guidelines,* then *View prior authorization list* for services that require prior authorization under Medi-Cal. The lists are updated monthly.

6.2: Blue Shield Medicare Advantage Plan Benefits and Exclusions

Added language throughout section noting where Prior Authorization lists are located on the Provider Portals for D-SNP Medicare and Medi-Cal members, as follows:

For D-SNP members, please refer to Blue Shield's Medicare Prior Authorization List located on Provider Connection at blueshieldca.com/provider under *Authorizations, Prior authorization forms and list,* then *Prior authorization list for Blue Shield*, for services that require prior authorization under Medicare. View the Blue Shield of California Promise Health Plan (Blue Shield Promise) Medi-Cal Prior Authorization List at blueshieldca.com/promise/providers under *Clinical policies, procedures and guidelines,* then *View prior authorization list* for services that require prior authorization under Medi-Cal. The lists are updated monthly.

Blue Shield Medicare Advantage Plan Benefits

Outpatient Benefits

Added the following language:

For Medicare-Medi-Cal Dual Eligible Special Needs Plans (D-SNP) Participants, please refer to Blue Shield's Medicare Prior Authorization List located on Provider Connection at blueshieldca.com/provider under *Authorizations, Prior authorization forms and list,* then *Prior authorization list for Blue Shield*, for services that require prior authorization under Medicare. View the Blue Shield of California Promise Health Plan (Blue Shield Promise) Medi-Cal Prior Authorization List at blueshieldca.com/promise/providers under *Clinical policies, procedures and guidelines,* then *View prior authorization list* for services that require prior authorization under Medi-Cal. The lists are updated monthly.

Exclusions to Blue Shield Medicare Advantage Plan Benefits

General Benefit Exclusions

Added the following language:

For D-SNP members, for services that require a prior authorization, new CMS, DHCS and DMHC guidelines will require shared and full-risk IPAs to ensure their internal processes support the new regulation. This means that some IPAs will need to work with Blue Shield and Blue Shield Promise somewhat differently. Blue Shield of California and their delegates will consider both Medicare and Medi-Cal coverage criteria as an integrated organization determination. Please see Prior Authorization Lists below.

Initial Organization Determinations (Treatment Authorization Request Decisions) Standards

Second Opinions (California Health and Safety Code 1383.15)

Added the following language:

For D-SNP Plans, Second Opinions are reviewed under the Medi-Cal Benefit. See the *Blue Shield Promise Medi-Cal Provider Manual* for process steps.

UM Decision Timeliness Standards – Centers for Medicare & Medicaid Services (CMS)

Added the following to the UM Decision Timeframes – CMS Standards Table:

Type of Request	Decision	Notification Timeframes
For D-SNP Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	Decision must be made within 5 working days from receipt of the information reasonably necessary to render a decision, but no later than 14 calendar days from receipt of request (if it for a Medicare service). Extensions are not permitted for D-SNP Members in Los Angeles and San Diego Counties.	Practitioner: Within 24 hours of the decision (for approvals, denials, and modifications). Member: Within 2 business days of the decision (for denials/modifications decisions).

Denial Standards

Added the following language:

D-SNP Coverage Decision Letters can be found on Provider Connection at blueshieldca.com/provider in the *Forms* section.

Commercial Required Reporting to Health Plan

Updated the following reporting requirements found in the Required Reporting to Health Plan – Commercial Standards Table:

ACTIVITY / FUNCTION	ENTITY's RESPONSIBILITIES	REPORTING FREQUENCY	SUBMIT TO
Commercial Shared Risk Authorizations (For groups with shared risk contracts ONLY)	Includes all services that entities approve and deny that are paid out of shared risk pool. These include: • Acute and skilled admits: med/ surg/ rehab/ detox/ MHSA- mental health and substance use disorder	Weekly Approval/denial data files ("Authorization Logs") must be delivered via secure email or Secure File Transfer Protocol (STFP) file to Blue Shield using either the IPA9 or IPA10 file layout. To initiate the delivery of authorization logs by means of a STFP or to obtain the IPA9 or IPA10 Blue Shield standard file layout and data dictionary, please email Medicare Care Solutions at IPAAuths@blueshieldca.com. Only shared risk services for which IPA/Medical Group is delegated to perform UM and Blue Shield is responsible for claim adjudication are required on the data file. Authorization logs must be sent, at a minimum, on a weekly basis in order to ensure timely data processing. IPA approvals, denials, and partial denials should be delivered on one file. If sent via email, the data MUST be delivered in a file format that is suitable for data processing, such as excel spreadsheet or	IPAAuths@ blueshieldca. com

ACTIVITY / FUNCTION	ENTITY's RESPONSIBILITIES	REPORTING FREQUENCY	SUBMIT TO
	• DME • Home Health • Hospice Check your individual group shared risk matrix for additional details.	delimited fixed width file. Please note: Any data file which does not comply to the format, content requirements and/or delivery frequency will be considered out of compliance, rejected by Blue Shield, and returned to the IPA/medical group for correction and resubmission. The following information is required on the Authorization Log. Please do not modify (add or subtract) any of these data elements from the Authorization Log. • Subscriber ID # • Patient Last Name • Patient First Name • Patient Date of Birth (mm/dd/yyyy) • Health Plan/Line of Business (CMC, Medi-Cal, Medicare Advantage or Commercial) • Request Type (Inpatient, Service or Medication) • Place of Service (Using CMS Industry Standard Place of Service Code Set and/or Name/Description: POS 11/Office, POS 21/Inpatient Hospital, POS 31/Skilled Nursing Facility) • Admission Bed Type or Level of Care (Using industry standard descriptions: Acute Rehabilitation, Acute Behavioral Health, ICU, LTAC, Med Surg, NICU, NICU Level 1, Observation, SNF Level 1, Sub-Acute, etc.) • First date of service or Admit date (mm/dd/yyyy) • Last date of service or Discharge date (mm/dd/yyyy) • Diagnosis Code(s) (ICD-10-CM Codes) – Primary code and up to 3 additional codes, if applicable • Procedure Code(s) (CPT-4/HCPC Codes and for inpatient facility claims only ICD-10-PCS Codes) – Primary code and up to 13 additional codes, if applicable • Units: Number of procedures, treatments, , days, sessions, or visits • Servicing Provider Name • Servicing Provider NPI # • Facility Name (if applicable) • Facility NPI # (if applicable) • Requesting Provider Name • Requesting Provider NPI # • Authorization or Decision Reference # • Blue Shield IPA/Medical Group Provider Identification # (i.e., IPxxxxxxxxxx) – It is highly recommended to include your Blue Shield PIN # to expedite processing. If unknown, the PIN # can be obtained from your Blue Shield Provider Relations representative. • Receipt Request Date (Date provider requested authorization from IPA/medical group) • Decision (Approved, denied, partially denied or void) • Full/Partial Denial Reason (i.e., Not medically necessary, not a benefit, etc.) • Decision Date (mm/dd/yyyy) • Discharge Diagnosis (if applicable) • Discharge Status (i.e., To Home, SNF…., if applicable)	
Commercial Contracted entity, Denial Logs	Required to use Plan denial letter templates and required data	Weekly submission of denial logs showing 100% of all denials must be sent to Blue Shield of California, at minimum, on a weekly basis in order to ensure timely data processing. Denial data files ("Authorization Logs") must be delivered via secure	IPAAuths@blueshieldca.com

ACTIVITY / FUNCTION	ENTITY's RESPONSIBILITIES	REPORTING FREQUENCY	SUBMIT TO
Pre-Service/ Concurrent/ Retrospective (ER, Claims)	elements for Commercial denials.	email or Secure File Transfer Protocol (STFP) file to Blue Shield using either the IPA9 or IPA10 file layout. To initiate the delivery of authorization logs by means of a STFP or to obtain the IPA9 or IPA10 Blue Shield standard file layout and data dictionary, please email Medicare Care Solutions at IPAAuths@blueshieldca.com. Only shared risk services for which IPA/Medical Group is delegated to perform UM and Blue Shield is responsible for claim adjudication are required on the data file. Authorization logs must be sent, at a minimum, on a weekly basis in order to ensure timely data processing. IPA approvals, denials, and partial denials should be delivered on one file. If sent via email, the data MUST be delivered in a file format that is suitable for data processing, such as excel spreadsheet or delimited fixed width file. Please note: Any data file which does not comply to the format, content requirements and/or delivery frequency will be considered out of compliance, rejected by Blue Shield, and returned to the IPA/medical group for correction and resubmission. The following information is required on the Authorization Log. Please do not modify (add or subtract) any of these data elements from the Authorization Log: • Subscriber ID # • Patient Last Name • Patient First Name • Patient Date of Birth (mm/dd/yyyy) • Health Plan/Line of Business (CMC, Medi-Cal, Medicare Advantage or Commercial) • Request Type (Inpatient, Service or Medication) • Place of Service (Using CMS Industry Standard Place of Service Code Set and/or Name/Description: POS 11/Office, POS 21/Inpatient Hospital, POS 31/Skilled Nursing Facility) • Admission Bed Type or Level of Care (Using industry standard descriptions: Acute Rehabilitation, Acute Behavioral Health, ICU, LTAC, Med Surg, NICU, NICU Level 1, Observation, SNF Level 1, Sub-Acute, etc.) • First date of service or Admit date (mm/dd/yyyy) • Last date of service or Discharge date (mm/dd/yyyy) • Diagnosis Code(s) (ICD-10-CM Codes) – Primary code and up to 3 additional codes, if applicable • Procedure Code(s) (CPT-4/HCPC Codes and for inpatient facility claims only ICD-10-PCS Codes) – Primary code and up to 13 additional codes, if applicable • Units: Number of procedures, treatments, , days, sessions, or visits • Servicing Provider Name • Servicing Provider NPI # • Facility Name (if applicable) • Facility NPI # (if applicable) • Requesting Provider Name • Requesting Provider NPI # • Authorization or Decision Reference #	

ACTIVITY / FUNCTION	ENTITY's RESPONSIBILITIES	REPORTING FREQUENCY	SUBMIT TO
		• Blue Shield IPA/Medical Group Provider Identification # (i.e., IPxxxxxxxxx) – It is highly recommended to include your Blue Shield PIN # to expedite processing. If unknown, the PIN # can be obtained from your Blue Shield Provider Relations representative. • Receipt Request Date (Date provider requested authorization from IPA/medical group) • Decision (Approved, denied, partially denied or void) • Full/Partial Denial Reason (i.e., Not medically necessary, not a benefit, etc.) • Decision Date (mm/dd/yyyy) • Discharge Diagnosis (if applicable) • Discharge Status (i.e., To Home, SNF…., if applicable)	