October 11, 2019

Subject: Notification of January 2020 Updates to the Blue Shield Independent Physician and Provider Manual

Dear Provider:

We have revised our Independent Physician and Provider Manual. 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 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 2020 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
Blue Shield of California
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 RIGHTS AND RESPONSIBILITIES

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

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.

Section 2: Provider Responsibilities

PROVIDER CERTIFICATION

The Provider Enrollment Application has been replaced with the Record Application form and Information Change form. The Reporting Provider Status Changes chart has been updated to reflect the new forms and additional required documentation such as tax verification and W-9 documents.

The new forms are available on Provider Connection at blueshieldca.com/provider, under Find forms at the bottom of the page, then Network and procedure forms.

Updated contact information for the Provider Information and Enrollment team, as below:

<table>
<thead>
<tr>
<th>Email</th>
<th>BSC <a href="mailto:ProviderInfo@blueshieldca.com">ProviderInfo@blueshieldca.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Postal mail</td>
<td>Provider Information and Enrollment P.O. Box 629017 El Dorado Hills, CA 95762-9017</td>
</tr>
</tbody>
</table>
Section 2: Provider Responsibilities (cont’d.)

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.

HOME-BASED PALLIATIVE CARE PROGRAM PROVIDERS

Enrolling a Member

Added the list of elements that providers must include in the enrollment notification to Blue Shield, as below:

- Member’s Blue Shield of California Subscriber ID number
- Member First Name
- Member Last Name
- Member DOB
- Member Diagnosis (ICD-10 code)
- Date of Enrollment into the program
- Palliative Care treating provider name
- Referral Date
- Referral Source

Quality Review Guidelines

Added section for palliative care program quality guidelines, as below:

Blue Shield’s Palliative Care Program will perform a biweekly and quarterly quality review. The review is to ensure an effective and efficient delivery of palliative care services to our members, your patients. It is designed to evaluate the cost and quality of medical services provided by our home-based palliative care providers.

The quality review has the following objectives:

- Assist in the promotion and maintenance of achievable quality of care.
- Ensure patients receive care that is consistent with their preferences.
- Initiate process improvement activities and focus resources on a timely resolution of identified problems.
- Identify patterns of utilization including overutilization, underutilization, and inefficient use of resources.
- Educate medical providers and other health care professionals on appropriate and cost-effective use of health care resources.
- Facilitate communication and collaboration among members, providers and the palliative care team to support cooperation and appropriate utilization of health care benefits.
Section 2: Provider Responsibilities (cont’d.)

Quality Review Guidelines (cont’d.)

- Help tell a consistent story of the Blue Shield Palliative Care program and the effectiveness of our providers.

The process for the review is:

- **Biweekly**: Providers will complete the provider enrollment information template.
- **Quarterly**: Providers will complete the utilization report and submit patient and family satisfaction surveys. Providers have 15 days to submit the completed quarterly quality review report spreadsheet and copies of the satisfaction surveys to Blue Shield Palliative Care.
- Blue Shield will provide feedback on the biweekly and quarterly quality 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.

Quality Areas of Focus

1. Documentation of patient demographics, clinical information, referral information, advance directive and POLST.
2. Confirmation of medical decision maker and patient’s goals of care decision.
3. Utilization of Emergency Room and Inpatient Hospital Stays.
4. Patient and family satisfaction surveys.

Completing the Biweekly requirement

1. Documentation of patient demographics
   - Patient’s subscriber ID, name, date of birth.
2. Documentation of clinical information
   - ICD-10 code and diagnosis name.
3. Documentation of referral information
   - Referral date and source.
4. Documentation of enrollment and disenrollment information
   - Enrollment date, disenrollment date and reason.
5. Documentation of advance directive
   - Patient’s wishes regarding their medical treatment. Providers must have a copy in the patient’s medical record to respond yes.
6. Documentation of POLST
   - Physician Orders for Life Sustaining Treatment (POLST) providing specific medical orders. Providers must have a copy in the patient’s medical record to respond yes.
7. Confirmation of patient’s code status decision
   - Patient’s wishes on the level of treatment preferred i.e. Full Code, DNR etc.
8. Confirmation of medical decision maker
   - Patient’s healthcare proxy, i.e., a family member, friend, lawyer, or someone in their social or spiritual community. A person who can make life and medical decisions on patient’s behalf. Providers must have the named decision maker in the patient’s medical record to respond yes.
Section 2: Provider Responsibilities (cont’d.)

Quality Review Guidelines (cont’d.)

How to complete this requirement?

In the provider enrollment information template, providers must complete the required sections using free text or drop-down options when applicable. Completed reports should be emailed to bscpalliativecare@blueshieldca.com.

Completing the quarterly requirement

1. Utilization of Emergency Room and Inpatient Hospital Stays

What do we mean?

Planned or appropriate ER visits/hospital stays include:

- Expected based on medical necessity (could be scheduled or otherwise).
- Appropriate based on unanticipated health crisis or trauma.
  Examples of both - scheduled chemotherapy admissions, scheduled surgeries, or repair of a hip fracture.

Unplanned or inappropriate ER visits/hospital stays mean:

- Unplanned based on medical necessity due to badly managed health care issues or health crises that should have been anticipated/prevented.
- Inappropriate - ER Visits for preventable issues, ER visits for preventable treatments that occur within 24 - 72 hours of a previous visit.
  Examples - unscheduled treatments for poorly managed pain, readmission within days/a couple of weeks of hospital discharge.

How to complete this requirement?

In the utilization report spreadsheet, providers must complete the required section in the IP and/or ER tabs. Completed utilization reports should be emailed to bscpalliativecare@blueshieldca.com.

2. Patient and family satisfaction surveys

What do we mean?

A survey that captures patient and/or family members’ perceptions about the quality of the palliative care received. The aggregated results must be reported to the Blue Shield Palliative Care Program Team within thirty (30) days of the end date of the collection period of the quarterly survey.

How to complete this requirement?

Providers must email completed surveys for all active patients in the quarter to bscpalliativecare@blueshieldca.com.

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

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.

PRIOR AUTHORIZATIONS

Specialty Drug Prior Authorization for the Medical Benefit

Updated language to indicate that certain specialty drugs covered in the members’ medical benefit may require prior authorization to establish medical necessity, step therapy requirements and authorization for place of service. If the authorization for the place of care does not match the claim, the medication claim may be denied.

PRIOR AUTHORIZATION LIST FOR NETWORK PROVIDERS

Updated Prior Authorization for Laboratory Services to indicate that Prior Authorization may be required.

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

**Drug Formulary**

Noted for Commercial Plans, prior authorization requests may be submitted electronically through the electronic health record, if available.

**Specialty Drugs**

Added language indicating that Specialty Pharmacies provide 30-day supplies of Specialty Drugs:

New prescriptions for specialty drugs should be sent to a Network Specialty Pharmacy who will provide no more than a 30-day supply of Specialty Drugs by mail or, upon a member’s request, at an associated retail pharmacy for pickup, if available.

Section 4: Billing and Payment

**Provider Payment**

**Blue Shield Provider Allowances**

Added language in boldface type below:

“Blue Shield Provider Allowances” is the term used to describe the compensation schedules for providers who render medical, surgical, or other services to Blue Shield members. Providers are contractually obligated to accept the lesser of the current Blue Shield Provider Allowances or Provider’s billed charges, including the member’s applicable copayment, as payment in full.

**Summary of Blue Shield Provider Allowances**

Noted that CMS published ASP pricing will continue to apply unless CMS discontinues the HCPCS code. Added HCPCS for drug claims as below:

- For drugs, CPT, or HCPCS and NDC are required for payment regardless of reimbursement methodology.

**CRNA Billing**

Removed section. Updated payment policies can be found on Provider Connection at blueshield.ca.com/provider under Claims then Policies & guidelines.

Added the following new section:

**Home Infusion Billing**

Home infusion claims for medications covered under the medical benefit must be submitted with the appropriate National Drug Code (NDC) with total units of measurement dispensed together with the associated Healthcare Common Procedure Coding System (HCPCS) drug code. Unless otherwise agreed to in writing by Blue Shield, home infusion providers are required to submit claims directly through Blue Shield’s ancillary care management vendor.

Infusion therapy supplies should be billed utilizing the appropriate per diem HCPCS codes (i.e., S codes) for the specific drug or drug category. When billing for commercial benefit programs, the per diem HCPCS must be billed on the same claim as the corresponding drug for the same dates of service. When billing for Medicare Advantage benefit programs, home infusion providers are required to submit separate claims: the drug under the pharmacy benefit and per diem fees under the medical benefit.
Section 4: Billing and Payment (cont’d.)

Office-Administered Injectable Medications

Clarified that the Drop Ship program only applies to Commercial PPO plans.

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

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.

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.


**PPO PRIMARY CARE PHYSICIAN REQUIREMENT FOR IFP PPO MEMBERS**

Updated language to indicate that ALL individual and family plan (IFP) PPO benefit plan members are required to have a primary care physician (PCP) of record. Previously, IFP PPO grandfathered members were excluded from this requirement.
Section 5: Blue Shield Benefit Plans and Programs (cont’d.)

FEDERAL EMPLOYEE PROGRAM (FEP)

About the Blue Cross and Blue Shield 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.

Required Prior Authorization

Updated the following services requiring prior authorization:

<table>
<thead>
<tr>
<th>Prior Approval is required for:</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes</td>
<td>Prior approval is required for BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes whether performed for preventive or diagnostic reasons. Note: Necessary medical evidence for BRCA related genetic testing includes the results of genetic counseling. Genetic counseling and evaluation services are required before preventive BRCA testing is performed.</td>
</tr>
<tr>
<td>Surgical services</td>
<td>Morbid Obesity - See the Blue Cross Blue Shield Service Benefit Plan Brochure for requirements. 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). Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ). Breast reduction or augmentation not related to treatment of cancer. Reconstructive surgery for conditions other than breast cancer. Orthopedic procedures: hip, knee, ankle, spine, shoulder and all orthopedic procedures using computer-assisted musculoskeletal surgical navigation. Rhinoplasty, Septoplasty and Varicose vein treatment. Separate Inpatient (IP) Authorization is needed for all IP admissions.</td>
</tr>
</tbody>
</table>
Organ/tissue transplants – Prior approval is required for both the procedure and the facility

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.

If you travel to a Blue Distinction Center for Transplants, prior approval is also required for travel benefits.

The organ transplant procedures must be performed in a facility with a Medicare-Approved Transplant Program. Medicare’s approved programs are listed at: [https://qcor.cms.gov/main.jsp](https://qcor.cms.gov/main.jsp)

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.

Note: 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.

All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service telephone number listed on the back of their ID card before obtaining services.

**Added** the following services requiring prior authorization:

<table>
<thead>
<tr>
<th>Prior Approval is required for:</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty DME</td>
<td>Specialty hospital beds, deluxe wheelchairs, power wheelchairs and mobility devices including scooters and related supplies.</td>
</tr>
<tr>
<td>Gene Therapy and Cellular Immunotherapy</td>
<td>Including Car-T and T-cell receptor therapy.</td>
</tr>
<tr>
<td>Air Ambulance Transport (Non-Emergent)</td>
<td>Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval.</td>
</tr>
<tr>
<td>Outpatient Intensity Modulated Radiation Therapy (IMRT)</td>
<td>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.</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>Cardiac Rehab and Pulmonary Rehab.</td>
</tr>
<tr>
<td>Devices</td>
<td>Cochlear implants and external prosthetic devices including microprocessor controlled limb prosthesis and electronically and externally powered prosthesis.</td>
</tr>
<tr>
<td>Outpatient Residential Treatment Center Care</td>
<td>For any condition.</td>
</tr>
</tbody>
</table>
| 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. |
Section 5: Blue Shield Benefit Plans and Programs (cont’d.)

MEDICARE SUPPLEMENT PLANS

Claims Assignment

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

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

*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](http://www.wellvolution.com) to get started.
Section 5: Blue Shield Benefit Plans and Programs (cont’d.)

Wellvolution (cont’d.)

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 1 - B ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Removed this form from the manual. This form can be found on Provider Connection at blueshieldca.com/provider under Guidelines & resources, Forms, then Patient care forms.

APPENDIX 2 - D PALLIATIVE CARE PATIENT ELIGIBILITY SCREENING TOOL

Updated the tool. This form can be found on Provider Connection at blueshieldca.com/provider under Guidelines & resources, Forms, then Patient care forms.

APPENDIX 3 - A CLINICAL PRACTICE GUIDELINES

Removed this appendix from the manual. Clinical Practice Guidelines can be found on Provider Connection at blueshieldca.com/provider under Guidelines & resources, Guidelines & standards, then Clinical practice guidelines.
APPENDIX 4-D CMS 1500 GENERAL INSTRUCTIONS

**Updated** instructions for Blocks 19 and 23, as below:

Block 19: Use this to identify additional information about the patient's condition or the claim.
Block 23: Enter authorization number from Blue Shield or members group (IPA) when applicable.

APPENDIX 4-H LIST OF OFFICE-BASED AMBULATORY PROCEDURES

**Added** the following procedure codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0525T</td>
<td>Ins/Replace Complete IIMS</td>
</tr>
<tr>
<td>0529T</td>
<td>Interrog Dev Eval IIMS IP</td>
</tr>
<tr>
<td>0530T</td>
<td>Removal Complete IIMS</td>
</tr>
</tbody>
</table>

**Removed** the following procedure codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11100</td>
<td>Biopsy, skin lesion</td>
</tr>
<tr>
<td>11101</td>
<td>Biopsy, skin add on</td>
</tr>
<tr>
<td>64550</td>
<td>Apply neurostimulator</td>
</tr>
<tr>
<td>0190T</td>
<td>Place intraoc radiation src</td>
</tr>
</tbody>
</table>

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 your independent physician practice 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, your independent physician practice 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 a another licensee of the Blue Cross Blue Shield Association in the State of California exclusively to process transactions for its members.
APPENDIX 5-A THE BLUECARD PROGRAM (cont’d.)

Submitting BlueCard Claims (cont’d.)

*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 Submitters 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. Or submit an EDI inquiry online on Provider Connection.

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."

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, Guidelines and Standards, then Other Payor Summary List.
**APPENDIX 6-A 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:

<table>
<thead>
<tr>
<th>#</th>
<th>Responsible Party</th>
<th>Activity</th>
<th>Time Requirement</th>
</tr>
</thead>
</table>
| 8.  | IPA/MSO           | **Faxes records to:**  
1.) Health Services Advisory Group, Inc.  
Copy of NOMNC with member's signature or documentation of refusal to sign, copy of DENC and copy of enrollee's medical records.  
2.) Blue Shield 65 Plus (HMO):  
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  
Member/representative:  
Mails DENC. Upon request, all documents sent to Health Services Advisory Group, Inc. | Day 1             |
| 9.  | IPA/MSO, BSC      | **HMO ONLY:** IPA makes decision to rescind the termination date and send new letter to member.  
Fax copy of letter to Health Services Advisory Group, Inc.  
**PPO ONLY:** Blue Shield makes decision to rescind the termination date and send new letter to member.  
Fax copy of letter to Health Services Advisory Group, Inc. | Resolved Go to step 14 |
| 10. | Health Services Advisory Group, Inc. | **Reviews documents**  
Renders decision to uphold or overturn.  
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. | Day 1  
If Resolved Go to step 14 |