blue california

October 15, 2021

Subject: **Notification of January 2022 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, 2022.

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 *Independent Physician and Provider Manual* be emailed to you or mailed to you in CD format, 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 2022 version of this manual, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

T12060 (10/21)

# UPDATES TO THE JANUARY 2022
# *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.

## Section 1: Introduction

### FRAUD PREVENTION

***Noted** that Health Integrity, LLC, the Medicare Drug Integrity Contractor (MEDIC) in California, is now known as Qlarant Integrity Solutions, LLC.*

#### Medicare Compliance and Fraud, Waste, and Abuse (FWA) Training Requirements

***Updated** the section to indicate that Blue Shield requires all FDRs to complete FWA training on an annual basis. Training materials can be accessed at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.

## Section 2: Provider Responsibilities

### HOME BASED PALLIATIVE CARE PROGRAM PROVIDERS

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

#### Home-Based Palliative Care Program Recertification Guidelines

The purpose of the recertification process and required form is to justify the member's ongoing enrollment in the home-based palliative care program.

The Recertification must be completed by an MD, NP or PA involved in the member's care using the Palliative Care Services Recertification Form located on the Provider Portal. The member's recertification for the Home-Based Palliative Care Program is required every six months upon admission to the program. The form should be submitted up to 15 days before the end of the six-month enrollment period or no later than 2 business days after the start of the next enrollment period. The form shall be sent to bscpalliativecare@blueshieldca.com for review.

Failure to comply with this requirement may result in corrective action, up to and including contract termination.

#### Quality Review Guidelines

***Added** the following to the list of quality review objectives:*

- Ensure minimum monthly visit frequency expectations are being met.

*The monthly Quality review process has been **deleted and replaced** with the following:*

- Providers will complete the enrollment/disenrollment report. Providers have 7 days to submit the completed report to Blue Shield Palliative Care team.
- Blue Shield Palliative care team will work with providers to set acceptable targets. Blue Shield will provide feedback in Interdisciplinary Teams (IDTs) 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.

***Removed*** *the following sections as they are no longer program requirements:*

- Completing the Utilization Report
- Completing the Satisfaction Survey Requirement

### Completing the Enrollment and Disenrollment Report

***Added*** *member email to reporting requirements.*

## Service Accessibility Standards

***Updated*** *language in boldface type below regarding compliance with access standards:*

Groups that are found non-compliant with the access standards **may** be required to submit a corrective action plan containing details on how the IPA/medical group will achieve and maintain compliance.

## Provider Availability Standards for Commercial Products

### Geographic Distribution

***Deleted and replaced*** *the following standards:*

| CATEGORY | PRODUCT TYPE | STANDARD | COMPLIANCE TARGET |
|---|---|---|---|
| High Volume Specialists<br>High Impact Specialists | HMO/POS<br>PPO - CDI<br>PPO – DMHC<br>IFP ePPO<br>CCSB HMO/PPO | One of each type of Top High-Volume Specialists and High Impact Specialists within 30 miles of each member | 90% |
| Hospitals | | One hospital within 15 miles of each member | 100% |
| Pharmacy | | One Pharmacy in 15 miles | 90% |
| Acupuncturist | PPO | Urban/Suburban: 1 of each specialty within 20 miles of each member's residence or workplace or equivalent to 30 minutes.<br>Rural: 1 of each specialty within 45 miles of each member's residence or workplace or equivalent to 60 minutes. | 90% |

### LANGUAGE ASSISTANCE FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY (LEP)

*__Added__ Korean to list of Blue Shield threshold languages and __noted__ that Blue Shield does not delegate overall responsibility for culturally and linguistically appropriate services to contracted providers unless otherwise noted in their contract with Blue Shield.*

*__Added__ item to reference section for Industry Collaboration Effort.*

- Industry Collaboration Effort (ICE) Cultural and Linguistics Provider Toolkit http://www.iceforhealth.org/library.asp?sf=&scid=1284#scid1284

## Section 3: Medical Care Solutions

### MEDICAL NECESSITY

*This section has been __deleted and replaced__ with the following to align with the Blue Shield UM Program Description:*

**Medical Necessity (Medically Necessary)***

Coverage for Mental Health and Substance Use Disorder (MH/SUD) services is provided under the same terms and conditions as those applied to medical/surgical services conditions.

Medically necessary treatment of a mental health or substance use disorder* means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

*This definition applies to MH/SUD benefits in fully-insured products.

**Medical Necessity (Medically Necessary)****

Benefits are provided only for services which are medically necessary.

Services that are medically necessary include only those 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.

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.

**This definition applies to medical/surgical benefits in fully-insured and self-funded products and to MH/SUD benefits in self-funded commercial products.

## UM Criteria and Guidelines

***Removed*** *World Professional Association for Transgender Health (WPATH) as one of the review criteria from the language below. WPATH is used for medical services and not MH/SUD reviews.*

***Added*** *language in boldface type below:*

For fully-insured products, Mental Health and Substance Use Disorder medical necessity review is conducted by Blue Shield's MHSA and utilizes the American Society of Addiction Medicine (ASAM) criteria, Level of Care Utilization System (LOCUS) guidelines, Child and Adolescent Level of Care Utilization System (CALOCUS) guidelines and Early Childhood Service Intensity Instrument (ECSII) guidelines. Additional guidelines may be added as they become available from non-profit professional associations in accordance with California law. **Medical services for the treatment of gender dysphoria, eating disorder or substance use disorder are reviewed by Blue Shield utilizing the criteria as outlined in the UM Program Description.**

## Blue Shield Medical & Medication Policies

### Medical Policy

***Added*** Evidence Street *to the list of technologies that the Blue Shield Medical Policy Committee uses for medical and behavioral health indications.*

### Medication Policy

***Updated*** *authorization language in boldface type below:*

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. Step therapy may also apply. Refer to the medication policy. **For Blue Shield Medicare Advantage HMO Members, Blue Shield follows Medicare guidelines for risk allocation, 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 **does not match the authorization** or 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

***Updated*** *language in boldface type below:*

For urgent or emergent admissions, Blue Shield must be notified within one business day following **stabilization of the member**. In addition, there are selected services and procedures which may be done in an ambulatory care setting or inpatient facility for non-emergent care that require mandatory prior authorization review for medical necessity, along with the prior authorization needed for an inpatient admission. Requests may be submitted to Blue Shield Medical Care Solutions via telephone, fax, or U.S. mail. In addition, providers have the option to complete, submit, attach documentation, track status, and receive determinations for medical and pharmacy prior authorizations via AuthAccel, Blue Shield's online authorization tool. Registered users may access the tool in the *Authorizations* section after logging into Provider Connection at blueshieldca.com/provider.

### Specialty Drug Prior Authorization for the Medical Benefit

***Added*** *the* "use of biosimilar first" *to the list of policies that providers must adhere to when prior authorizing medications for coverage.*

## PRIOR AUTHORIZATION LIST FOR NETWORK PROVIDERS

### Mental Health and Substance Use Disorder

***Removed*** *from list of services requiring prior authorization:*

- Office-based Opioid Treatment
- Psychological Testing for a mental health disorder

***Added*** *to list services requiring prior authorization:*

- Neuropsychological Testing should be considered for coverage through the patient's mental health benefit when:
  - After completion of a comprehensive Behavioral Health evaluation and neurological evaluation, if the Behavioral Health provider or neurologist determines the neuropsychological testing is required, the provider will request authorization and coordinate the request, Blue Shield MHSA will cover Neuropsychological testing when, the purpose of testing is to clarify whether there is a psychiatric diagnosis (even when medical conditions are present).

***Updated*** *Medical Care Solutions contact information for Mental Health and Substance Use Disorder Medicare Advantage plans:*

- (800) 541-6652 Option 6
- Fax: (844) 807-8997
- Online at blueshieldca.com/provider under *Authorizations*, then *Request Medical Authorization*.

## Claims Processing

***Removed*** *the following language from electronic submission sections throughout this Section 4. Claims are not required to be submitted electronically, however, will be processed faster when submitted this way.*

All Blue Shield-contracted providers are required to submit claims electronically or via web/automated solution that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

If you do not submit a complete claim in one of these formats, it may not be accepted or may possibly be denied, and you will need to resubmit the claim in an acceptable format.

### Real Time Claims Settlement

***Deleted and replaced*** *the Real Time Claims Settlement – Future State section below:*

To further realize our long-term solution, Blue Shield is working to make claims processing automated. These offerings will revolutionize how we as an industry process claims and are expected to begin rolling out in 2022. The upcoming claims processing solutions are further defined below.

Blue Shield is working to create a platform for a direct system to system connection between providers and Blue Shield. This solution will make it possible for claims to be automatically generated, eliminating all administrative burden from providers. This will be accomplished through a connection with the provider's Electronic Health Records (EHR) system and Revenue Cycle Management (RCM) system to create and send a claim to Blue Shield through a digital connection to be adjudicated in real-time.

## Provider Payment

### Blue Shield Provider Allowances

***Added/updated*** *language to support current operations in boldface type below:*

Blue Shield Provider Allowances compensate physicians and other healthcare professionals appropriately for medical services they render by capturing actual time, skill, training, and costs associated with providing the service. Blue Shield uses a variety of methodologies and factors when determining physician and other healthcare professional allowances to closely align payments with actual resources used by providers in rendering professional services. Reimbursement rates vary by region, of which Blue Shield has 24. Blue Shield also considers facility-based pricing for some procedures when establishing allowances.

**With the exception of new and deleted codes and drug and immunization allowances**, Blue Shield Provider Allowances are reviewed **no more often than** annually. **New and deleted codes are reviewed quarterly** as new CPT-4 and HCPCS Level II Codes are added or existing codes change, per the American Medical Association. **Blue Shield Provider Allowances for drugs and immunizations reimbursed using Average Sales Price (ASP) or Average Wholesale Price (AWP) methodologies are also reviewed quarterly.**

Except for **the quarterly updates to** Blue Shield Provider Allowances **specified above**, Blue Shield will give providers at least 45 working days' notice of changes to the Blue Shield Provider Allowances. Quarterly adjustments **for new and deleted codes and for drug and immunization** may be made without notification.

### Summary of Blue Shield Provider Allowances

***Added*** *"biosimilars" as another source in determining J Code allowances.* ***Added*** *the following to the summary of provider allowances:*

- Unlisted, unspecified, or miscellaneous codes
- These codes should be reported only if no other specific HCPCS code, including Category III HCPCS codes, does not exist to adequately describe the diagnosis, procedure, service, or item rendered. Reimbursement is based on review of the unlisted, unspecified, or miscellaneous code on an individual claim basis. When submitting a claim with an unlisted, unspecified, or miscellaneous code, the following information and/or documentation must be provided:
  - A written description, office notes or operative report describing the procedure or service performed.
  - An invoice and written description of items and supplies.
  - The corresponding NDC for an unlisted drug code.

## SPECIAL BILLING SITUATIONS

### Ancillary Claims Filing Requirements

***Added*** *language in boldface type below:*

For ancillary services, the local Blue Plan is defined as follows:

- Independent Clinical Labs**:** All claims for clinical laboratory services provided to Blue Plan members must be submitted to the Blue Plan located in the state or service area where the specimen was drawn, regardless of where the specimen is analyzed. **Where the specimen was drawn will be determined by the state of service area in which the referring provider is located.**

# Section 5: Blue Shield Benefit Plans and Programs

## MEDICARE PART D

### Medication Therapy Management Program (MTMP)

*This following has been* ***deleted*** *from the list of conditions eligible for the MTMP:*

- Dyslipidemia

## MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

### Blue Shield MHSA Covered Services for Commercial Plan Members

***Removed*** *World Professional Association for Transgender Health (WPATH) as one of the review criteria from the language below. WPATH is used for medical services and not MH/SUD reviews:*

The Blue Shield MHSA will utilize ASAM, LOCUS, CALOCUS, and ECSII for mental health and substance use disorder reviews for commercial members. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.

***Removed*** *from list of services requiring prior authorization by Blue Shield's MHSA:*

- Office-based Opioid Treatment
- Psychological Testing for a mental health disorder

*Added to list services requiring prior authorization by Blue Shield's MHSA:*

- Neuropsychological Testing should be considered for coverage through the patient's mental health benefit when:
  - After completion of a comprehensive Behavioral Health evaluation and neurological evaluation, if the Behavioral Health provider or neurologist determines the neuropsychological testing is required, the provider will request authorization and coordinate the request, Blue Shield MHSA will cover Neuropsychological testing when, the purpose of testing is to clarify whether there is a psychiatric diagnosis (even when medical conditions are present).

***Added** the following new sections describing ancillary benefits:*

## Ancillary Services

The following benefits are listed in the members' *Evidence of Coverage* (EOC) and will include the number of allowed visits and member copay responsibility. Providers are required to look up members benefits and eligibility at www.blueshieldca.com/provider, under eligibility and benefits, then benefits, under acupuncture and chiropractic to determine if the members plan includes these benefits as they may or may not be included and vary by plan.

### Acupuncture Services

For Blue Shield fully-insured plans, benefits for medically necessary acupuncture services for a maximum number of visits per calendar year when received from an American Specialty Health Group, Inc. (ASH Group) participating provider. Covered services must be determined as Medically Necessary by American Specialty Health Plans, Inc. (ASH Plans). This benefit includes an initial examination, subsequent office visits, acupuncture services, and adjunctive therapy specifically for the treatment of neuromusculoskeletal disorders, nausea, and pain up to the benefit maximum.

Questions concerning these benefits may be directed to:

ASH Plan Member Services (800) 678-9133

ASH Plan Provider Services (800) 972-4226

For Self-Funded, ASO, Shared Advantage, FEP PPO and BlueCard members, all medically necessary acupuncture services that are included in these plans are provided by Blue Shield's direct network of acupuncturists.

### Chiropractic Services

For Blue Shield fully-insured plans, benefits for medically necessary chiropractic services, including spinal manipulation or adjustment, when received from an American Specialty Health Group, Inc. (ASH Group) participating provider. Covered services must be determined as Medically Necessary by American Specialty Health Plans, Inc. (ASH Plans). This benefit includes an initial examination and subsequent office visits, adjustments, and adjunctive therapy up to the benefit maximum. Benefits are also provided for x-rays.

Members are referred to the primary care physician for evaluation of conditions not related to a neuromusculo-skeletal disorder and of evaluation for non-covered services, such as CT Scans or MRIs.

Chiropractic appliances are covered up to a maximum of $50 in a calendar year as authorized by ASH Plans.

Questions concerning these benefits may be directed to:

ASH Plan Member Services (800) 678-9133

ASH Plan Provider Services (800) 972-4226

For Self-Funded, ASO, Shared Advantage, FEP PPO and BlueCard members, all medically necessary chiropractic services that are included in these plans are provided by Blue Shield's direct network of chiropractors.

#### BLUE SHIELD BENEFIT PROGRAMS

**Additional Care Management Program Descriptions**

***Added*** *a new care management program called Connect. The program description is as follows:*

**Connect.** Connect offers an integrated, holistic, and personalized healthcare experience based on each member's needs, including a broad spectrum of robust, member-focused interventions driven by a smart-data platform with predictive analytics that leverage our best-in-class member care teams and digital wellness tools. The Connect care team is composed of specialists across claims and benefits, clinicians and care managers, pharmacists and technicians, behavioral health navigators, and social workers to address any questions that could be asked during the first call. In those rare instances in which additional information is needed and a call cannot be resolved, the Connect care team takes complete ownership for any remaining tasks and offers to call the member back once resolved. The Connect care team proactively engages members, either digitally or over the phone, when early interventions or extra communications might lead to better health outcomes. Members are guided to available programs and resources to address their health issues, prevent emergency-room visits, and avoid higher costs associated with inpatient admissions in the future.

## Appendices

#### APPENDIX 1-B BLUE SHIELD COMBINED ELIGIBILITY/CAPITATION REPORT

***Updated*** *the Commercial file layout.*

#### APPENDIX 2-A CPS BYLAWS

***Replaced*** *the bylaws with August 14, 2020 version.*

#### APPENDIX 4-D CMS 1500 GENERAL INSTRUCTIONS

***Added*** *language in boldface type below:*

**Durable Medical Equipment & Radiation Treatment Dates:** Enter the month, day, and year for each procedure using the format "MMDDYY." Report all services provided on the same day for the same patient using only one claim form to ensure correct benefit coverage. **Monthly Rentals must be coded with a date span**. Date spans on a single line should not cross months. Date spans on a single claim should not cross years.

**DME monthly rentals must be coded with 30 units and accompanying date span. See 24a Date(s) of Service for more information.**

### Appendix 4-E Where to Send Claims

***Updated*** *the BlueCard claims mailing address to the following:*

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630

### Appendix 4-G List of Office-Based Ambulatory Procedures

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

| | |
|---|---|
| 0228T | Njx tfrml eprl w/us cer/thor |
| 0230T | Njx tfrml eprl w/us lumb/sac |
| 0295T | Ext ecg complete |
| 0296T | Ext ecg recording |
| 0297T | Ext ecg scan w/report |
| 0298T | Ext ecg review and interp |
| 0525T | Insj/rplcmt compl iims |

### Appendix 5-A The BlueCard Program

***Updated*** *Blue Plan HPN to BLUEHPN throughout Appendix 5-A.*

***Updated*** *the BlueCard claims mailing address to the following:*

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630

#### How to Identify Members

***Added*** *language in boldface type below:*

**Those BLUEHPN products offered may include fully-insured and self-insured Blue plan members**. Language regarding benefit limitations is also included on the back of the BLUEHPN EPO member ID card. For these limited benefits, if you are not a BLUEHPN 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-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.

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