601 12th Street
Oakland, CA 94607

October 14, 2022

Subject: **Notification of January 2023 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, 2023.

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 2023 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

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

Member Rights and Responsibilities- Blue Shield HMO and PPO Commercial Members

Updated Member Rights and Responsibilities to align with current Evidence of Coverage (EOCs).

Blue Shield Medicare Compliance Program

Removed Medicare Compliance Managers, staff of compliance analysts and auditors, and delegated claims compliance and performance auditors from the list of team members who advise about CMS requirements and who monitor compliance within the organization and in relation to Blue Shield's representatives in the community.

Section 2: Provider Responsibilities

General Blue Shield Agreement Terms and Conditions

Removed the following bullet point from the list of administrative requirements and responsibilities to which all Blue Shield providers must adhere:

- Individual or group providers are limited to three practice locations per individual or group.

Administrative Compliance

General Administrative Criteria

Added /updated provider general administrative requirements relating to online directory publication and accuracy of directory data:

- Comply with the policy outlined below for inclusion in the Blue Shield Find a Doctor online directory:

  All providers with a contracted relationship with Blue Shield will display in the Blue Shield Find a Doctor online directory.

  Providers have an opportunity to leverage Provider Connection online tools to support the process of attestation and submitting provider directory information updates. Non-responsive providers will be suppressed from the directory until they have attested to their information.

There are two ways to update data:

1) Make changes directly on Provider Connection in the *Provider & Practitioner Profiles* section.;
2) Download your data via Provider Data Validation Spreadsheet and upload revisions to the site.

To discuss the information shared about your organization in the Blue Shield Find a Doctor online directory, please contact the Provider Information and Enrollment team at **(800) 258-3091**, from 6 a.m. to 6:30 p.m., Monday through Friday.

In order to reduce administrative burden on providers, Blue Shield may delegate some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the provider may work with the vendor in lieu of Blue Shield to complete directory maintenance tasks.

- Have an identifiable practice location to publish in the directory or clearly specify that services are provided in a telehealth setting only. Agree to immediately update any change in group/practice affiliation, change in address, billing information, telephone number, or any other provider demographic information required by Blue Shield for use in the directory or claims processes.
- Comply with Blue Shield's processes to attest to the accuracy of their data every 90 days in compliance with the 2020 Consolidated Appropriations Act (CAA).

Provider Certification

Deleted *and* ***replaced*** language regarding provider certification and how to request a new record for billing and claims purposes with the following:

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

To request a new record for billing and claims purposes, the application forms, or provider profile with equivalent data elements may be submitted to Provider Information & Enrollment by email or postal mail: Submit the completed application to:

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

To view, download or complete forms, please log in to Blue Shield's provider portal at blueshieldca.com/provider, click on *Find forms* at the bottom of the page, then *Network and procedure forms.*

Provider Certification

Reporting Provider Status Changes

Deleted *and* ***replaced*** the following bullet points, listing the minimum required data for all new providers and provider demographic adds, updates, or termination submissions, with the following bullet points:

- California license number or certification identifier as applicable
- Languages spoken by practitioner
- Languages spoken by others in the practice
- IRS reporting number
- NPI identifiers (practitioner and entity as applicable)
- Designation as PCP or specialist

Deleted the following bullet point, listing the minimum required data for all new providers and provider demographic adds, updates, or termination submissions:

- Identification of the IPA to which the practitioner should be added

Provider Certification

Reporting Provider Status Changes

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

Practice changes requiring supporting documentation:

- IRS reporting number changes
    - Providers are required to notify Blue Shield Provider whenever there is a change in their Tax reporting information.
    - Blue Shield follows IRS reporting policies using the IRS reporting name and number on file.
    - A new agreement, application materials and supporting certification documents are required when a contracted entity changes the IRS reporting number.
- Name Changes
    - Providers are required to provide supporting materials when a name is changed, while the legal entity name and tax reporting number remain the same.
    - Such name supporting materials include:
        - Fictitious Name Permit issued by the applicable California licensing authority
        - County issued Fictitious Name Statement
        - License issued by the applicable California licensing authority
        - Certification issued by the applicable certifying body
        - Legal Entity Name as filed with the California Secretary of State

Provider Responsibilities for Quality Management and Improvement

Deleted *and* ***replaced*** list of Quality Management and Improvement activities that Blue Shield solicits its providers to participate in, as follows:

Blue Shield actively solicits its network providers to participate and partner in Quality Management and Improvement activities as follows:

- QI Committees
- Credentialing, peer review and utilization management determinations
- Clinical QI workgroups
- Focus groups
- QI studies
- Investigation of member grievances and quality of care issues

All Blue Shield providers are required to participate in quality management and improvement activities by providing, to the extent allowed by applicable state and federal law, member information, medical records, and quality data for review of quality of care and service provided to members.

Quality Management activities are considered privileged communication in conjunction with peer review activities conforming to California Evidence Code Section 1157 and Section 1370 of the California Health and Safety Code.

Submission of Laboratory Results Data

Updated the contact information for the HEDIS Supplemental data team to HEDISSUPPDATA@Blueshieldca.com.

Service Accessibility Standards for Commercial and Medicare

Removed the following cells from chart for accessibility standards:

ACCESS TO CARE	STANDARD
Preventive Care Appointments Access to preventive care with a PCP, Nurse Practitioner, or Physician Assistant at the same office site as a member's assigned PCP.	Within 30 calendar days

Behavioral Health Geographic Access Standards

Deleted *and* ***replaced*** cells containing information about access standards for behavioral health providers with the following cells:

CATEGORY	ACCESS STANDARD	COMPLIANCE TARGET
Geographic Distribution of Behavioral Health Individual Practitioners including: - Psychologists - Psychiatrists - Master's Level Therapists	Urban: 1 within 10 miles of each member Suburban: 1 within 20 miles of each member Rural: 1 within 30 miles of each member	Urban: 90% Suburban: 85% Rural: 75%
Behavioral Health Member Ratio including: - Top 3 HVS and Substance Use practitioner	1 provider of each type (i.e., Psychologists, Psychiatrists, or Master's Level Therapists) to 20,000 members	100%

Provider Availability Standards for Commercial Products

Deleted *and* ***replaced*** the following sections of the Geographic Distribution chart:

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
Total PCPs	HMO/POS PPO – CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	One PCP within 15 miles or 30 minutes of each member	100%
PCP **General Practitioner** **Family Practitioner** **Internist** **Pediatrician**		One PCP within 15 miles or 30 minutes of each member	100%
Hospitals		One hospital within 15 miles of each member	90%
Acupuncturist and Chiropractor	PPO	Urban/Suburban: 1 of each specialty within 20 miles of each member's residence or workplace or equivalent to 30 minutes. Rural: 1 of each specialty within 45 miles of each member's residence or workplace or equivalent to 60 minutes.	90%

Provider Availability Standards for Commercial Products

Deleted *and* ***replaced*** with the following cells in the chart:

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
Top High-Volume Specialties and High-Impact Specialties to Member Ratio	HMO PPO-DMHC IFP-ePPO	1 OB/GYN to **5**,000 female members. 1 High-Volume Specialty of each type and 1 High-Impact Specialty to **10**,000 members.	100%

Moved the following cells from the Provider-to-Member Ration chart to the Linguistic and Cultural Requirement chart:

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
Ethnic/Cultural and Language Needs	HMO/POS PPO – DMHC	1 PCP speaking a threshold language to 1,200 members speaking a threshold language**	100%

Additional Measurements for Multidimensional Analysis for Commercial Products

***Deleted** and **replaced** with the following cells in the chart:*

METRICS	PRODUCT	STANDARD	FREQUENCY
Access and availability related member complaints and grievances	HMO/POS/ PPO-	Rate of complains/grievances ≤1 per thousand members per month (non-Medicare) Rate of complains/grievances ≤5 per thousand members per month (Medicare)	Assessed Quarterly against Standard
PCP Turnover	HMO/POS	10% change	Assessed Quarterly against Standard
Open PCP Panel	HMO/POS/ Directly Contracted HMO	70%	Assessed Annually against Standard

Additional Measurements for Multidimensional Analysis for Medicare Advantage Products

***Deleted** and **replaced** with the following cells in the chart:*

METRICS	COMPLIANCE TARGET	FREQUENCY
PCP Turnover Rate	10%	Semi-Annual

Section 3: Medical Care Solutions

Blue Shield Medical & Medication Policies

Medical Policy

***Deleted** and **replaced** the list of criteria for pharmaceuticals to be eligible for coverage, as follows:*

1. The pharmaceutical product is approved by the U.S. Food and Drug Administration for marketing in the U.S.
2. The formulary placement and medication coverage policy recommendations are based on the principles of evidence-based medicine, which is a review of scientific evidence from peer-reviewed published medical literature.
    a. Multi-center, randomized, prospective clinical trial results published in the peer-reviewed literature demonstrating the treatment to be at least as safe and effective as other established modalities of therapy are considered as best evidence.
    b. In absence of randomized controlled trials, lesser level of evidence, such as observational studies, medical society guidelines, and accepted community standard of practice will be considered.

***Added** 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 **requiring the use of preferred agents including generic or biosimilar drugs.**

Use of Out of Network Health Care Professionals and Facilities

Changed this section title from "Use of Non-Preferred/Non-Participating Providers" to "Use of Out of Network Health Care Professionals and Facilities" and *updated* references to the new terms throughout the section.

Referral to Out of Network Health Care Professionals and Facilities

Changed this section title from "Referral to Non-Preferred/Non-Participating Providers" to "Referral to Out of Network Health Care Professionals and Facilities" and *updated* references to the new terms throughout the section.

Prior Authorizations

Updated language to state that for urgent or emergent admissions, Blue Shield must be notified by the attending physician or the hospital within **24 hours** of admission. It previously stated, "within one business day following stabilization of the member."

Prior Authorization Response Times

Updated language in Medical Services section in boldface type below:

Non-urgent: Within five business days after receipt of request **if all the necessary information is received at the time of the request.**

Specialty Drug Prior Authorization for the Medical Benefit

Added the following language about specialty drug authorizations, in boldface type below:

Failure to meet medication policy criteria will result in a denial for lack of medical necessity in accordance with the member's benefit document for the specialty drug and/or place of service (i.e., outpatient hospital facility). Upon issuance of the denial, the member and provider will receive a denial notice with the appeal process outlined. Additionally, if the claim **for the drug or site of care** does not match the authorization, payment may be denied.

Drug Formulary

Mandatory Generic Drug Policy

Added "biosimilar" to language below:

Even when there is no generic equivalent for a brand-name drug, consider prescribing an alternative drug in the same class that is available as a generic **or biosimilar**.

Section 4: Billing

Provider Payment

Blue Shield Provider Allowances

Added the following bullet point to the list of services that are reimbursed on a statewide fee schedule:

- Expenses related to supplies, equipment, staff time, and activities for visits performed during a public health emergency declared on or after January 1, 2022, due to respiratory-transmitted infectious diseases that are billed under CPT code 99072.

Special Billing Situations

Ancillary Claims Filing Requirements

Updated the section to indicate that all claims for Durable/Home Medical Equipment and Supplies (D/HME) and Orthotics & Prosthetics (O&P) provided to Blue Plan members must be submitted to the Blue Plan located in the state or service area to which the DME or O&P is shipped, or in which it is purchased at a retail store.

Claim Inquiries and Corrected Claims

Corrected Claims

Deleted *and* ***replaced*** bullet point in list of instructions for submitting a corrected claim, with the following bullet point:

- Corrected claims should be submitted within 365 days from the claim finalized date unless otherwise specified in the contract.

Provider Appeals and Dispute Resolution

Unfair Billing and Payment Patterns

Added the following language as part of instructions for submitting an initial and final appeal:

Please submit on paper only. Digital media such as compact discs, USB data keys, flash drives, and other digital formats are not permissible. Submission of digital media will not be effective to initiate an appeal, and any digital media received by Blue Shield will be destroyed without review or further notice to the submitting party.

Section 5: Blue Shield Benefit Plans and Programs

Medicare Part D

Added the following section on covered Part D Medicare drugs:

Medicare Part D Covered Drug

A Part D covered drug is available only by prescription, approved by the Food and Drug Administration (FDA) (or is a drug described under section 1927(k) (2) (A) (ii) or (iii) of the Act), used and sold in the United States, and used for a medically accepted indication (as defined in section 1927(k) (6) of the Act). A covered Part D drug includes prescription drugs, biological products, insulin, and medical supplies directly associated with delivering insulin to the body,

including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B as described in specified paragraphs of section 1927(k) of the Act, and vaccines licensed under section 351 of the Public Health Service Act. The definition of a covered Part D drug excludes any drug, biological product, insulin, or vaccine for which as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual. In essence, if the drug is administered to the member or dispensed within the four walls of a provider's office or facility, it is a Part B medication. CMS' understanding that the practice of "brown-bagging" drugs is opposed by medical societies. CMS continues to urge providers to reinforce this message to their members. The following drug categories are covered by Medicare Part B and therefore excluded from Part D:

1) Any injectable or infusible drug that is defined by a Medicare contractor as usually not self-administrable (e.g., injectable chemotherapy) or
2) Any injectable or infusible drug that there exists a safety concern such that it would go against accepted medical practice for a particular injectable or infusible to be dispensed directly to a patient based on medical literature.

In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act. Medicare Part D establishes that the administration fee of a Medicare Part D vaccine is to be considered part of the Part D vaccine cost.

Medicare Part D

Medication Therapy Management Program (MTMP)

Updated list of criteria members must meet, in order to qualify for MTMP, as follows:

- Have three of the following conditions:
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Hypertension
  - Osteoporosis
  - Respiratory Disease
- Receive **eight** or more different covered Part D maintenance medications monthly

Blue Shield PPO Plans

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

Under a Blue Shield 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 in network health care professional or facility is used.

A member's copayments and deductible amounts for covered services will vary depending on whether he or she selects an in network health care professional or facility. Therefore, there is a financial incentive for members to use in network health care professionals and facilities.

If a member chooses to go to an out of network health care professional or facility, Blue Shield's

payment for a service by that out of network health care professional or facility may be substantially less than the amount billed. The member is responsible for the difference between the amount Blue Shield pays and the amount billed by out of network health care professionals and facilities. It is therefore to the member's advantage to obtain medical and hospital services from in network health care professionals and facilities.

The Virtual Blue PPO plan uses remote, digital engagement as the default care delivery method when appropriate. Members have access to virtual primary care and specialist care, including psychiatry and psychology. A care team consisting of a virtual PCP, health coach and behavioral health specialist help members get the care they need. When in-person care is either preferred by the member or referred to by the care team, members have access to both in network and out of network health care professionals and facilities as outlined above.

Our PPO Savings Plans (PSP) are PPO plans with a choice of deductibles, designed to allow qualified individuals to establish a tax advantaged account under federal guidelines. Most services provided by a preferred hospital provider require a percentage copayment.

All PSP plans function very differently than regular PPO plans. All benefits (including pharmacy) must accrue to the deductible. The only benefits that can be paid by Blue Shield prior to the deductible being met is preventive care. If a member chooses to go to a non-network hospital provider, Blue Shield's payment for a service by that non-network hospital provider may be substantially less than the amount billed. The member is responsible for the difference between the amount Blue Shield pays and the amount billed by non-network hospital provider. It is therefore to the member's advantage to obtain medical and hospital services from preferred hospital providers.

Blue Shield Medicare (PPO) Service Area

Added Orange and San Diego Counties to the Individual Blue Shield Medicare (PPO) Service Area.

Exclusions to Blue Shield Medicare (PPO) Benefits

Updated bullet point in list of exclusions that apply to the Blue Shield Medicare (PPO) prescription drug benefits, in boldface type below:

- Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B. **This includes any injectable or infusible drug that is defined by a Medicare contractor as usually not self-administrable (e.g., chemotherapy and supportive/adjunctive injectable drugs), any drug that is administered to the member or dispensed within the four walls of a provider's office or facility, or any drug BSC has determined, based on medical literature, there exist safety concerns such that it would go against accepted medical practice for a particular injectable or infusible drug to be dispensed directly to a patient.**

Federal Employee Program (FEP)

Mental Health and Substance Use Disorder Services for FEP

Updated language to indicate that telehealth visits were added to the list of types of outpatient professional service visits, for which a prior authorization is not required.

Medicare Supplement Plans

Claims Assignment

Moved "Benefit Plan G" to the section of the pay structure table to which Blue Shield pays 100% of the difference between Medicare's payment and billed charges.

Wellness and Prevention Programs

Removed CareTips Clinical Messaging section, as this is no longer a program that Blue Shield supports.

LifeReferrals 24/7℠

Updated language to indicate that members can talk to a referrals specialist and set up 3 sessions with a licensed therapist, in any six-month period, at no cost.

Wellness and Prevention Programs

Wellvolution

Revised entire section to reflect changes in our Wellvolution Program.

Added the following bullet point in list of programs offered through Wellvolution:

- Mental Health Programs – To support our members in achieving optimal whole person health, our mental health programs are perfect for members that are seeking opportunities to incorporate everyday mindfulness into their daily lives to reduce stress, increase resilience, and get a better night's rest as well as for members seeking support for low- to moderate- anxiety or depression. Programs include guided meditations, sleepcasts, mindfulness exercises, 24/7 Behavioral Health coaching, personalized care plan, and more.

Section 6: Supplemental Direct Contracting HMO Administrative Procedures and Responsibilities

HMO Member-Related Issues

Member-Initiated Primary Care Provider Change

Removed the following language, concerning how Blue Shield Medicare Advantage plan members may change their PCP, by calling the Blue Shield Medicare Member Services Department:

If they call by the 15th day of the month, the transfer will usually be effective on the first day of the following month.

Provider Status Changes

Primary Care Provider Termination Notification Requirements

Deleted *and* ***replaced*** numbers 1-3 of the following section:

Blue Shield has established procedures to ensure that our HMO members (Commercial and Medicare) are provided timely written notification in the event that a Blue Shield HMO primary

care provider terminates. This policy and procedure is specific to individual PCP terminations only. The following are requirements for Primary Care Provider Termination Notification:

1. Contracting IPA/medical groups must provide at least 90 days' advance written notice of a termination in accordance with Blue Shield's contractual requirements and the 1997 Balanced Budget Act (for Medicare Advantage members).
2. Notification to Blue Shield must include the following: termination reason (deceased, retirement from all practice, closed practice site, left IPA, etc.). Terminating provider identifiers such as name and NPI or California license number. When applicable, the name and NPI of the receiving PCP may be included for consideration in member reassignment.
3. Blue Shield provides affected members at least 60 calendar days' advance written notice of their primary care provider's termination which aligns with standard accreditation and regulatory requirements. The letter to the member includes notification of the PCP's termination, the termination date, their new PCP and/or IPA/medical group and the procedures for selecting another PCP by calling the Member Services toll free number.

   In very limited circumstances the IPA/medical group may be unable to provide the required advance notice of a primary care physician termination. In these circumstances, the IPA/medical group must work with the assigned Provider Relations Representative contact to facilitate the expedited transfer of impacted members to a new PCP.

   In such cases where the IPA/medical group is not the source of a PCP termination, Blue Shield will notify and reassign members as outlined in section Termination of Providers.

   The limited circumstances or exceptions referenced above include:

   - Death
   - Status change of medical license, or Medicare sanction and debarment, or any other sanction status which results in administrative termination due to the practitioner being ineligible to render care.
   - A determination by Blue Shield's Credentialing or Legal Departments after an investigation of "Grossly unprofessional conduct", which includes any criminal or fraudulent acts (e.g., allegations of molestation or abuse).
   - Relocation of practice out of the area without adequate notice.
   - Practice closure without adequate notice.
   - The physician is an employee of a medical group and resigns or is terminated effective immediately.

Appendices

Appendix 4-A Special Billing Guidelines and Procedures

Updated contact information for the Electronic Data Interchange (EDI) Help Desk. The help desk can primarily be reached by phone at (800) 480-1221 or email at EDI_BSC@blueshieldca.com. The online data inquiry form has been retired.

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

Drug Requirements - 837 Professional Claims

For billing purposes, **drugs must be submitted with a HCPCS code and NDC.** NDCs contain 11 digits in a fixed 5-4-2 configuration. **The NDC found on the outer package must be submitted. DO NOT submit NDC found on individual vials or doses.** If the NDC on a product does not contain 11 digits, leading zeros should be added to fill in the missing number(s) to maintain the 5-4-2 format.

Updated the following code chart in boldface type, as follows:

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
400	2400	SV101-2	Product/ Service ID	HCPCS	**J or Q** codes for home, **office** infusion/drugs

Added the following new section:

Genetic and Molecular Testing – 837 Professional Claims

A procedure description is required for Unlisted Genetic and Molecular Testing procedure codes with use of the Genetic Testing Unit (GTU). The specific GTU for each procedure code can be identified by accessing Concert Genetics Provider Portal at www.concertgenetics.com/join-blue-shield-california. Providers are required to bill according to the CPT coding established in the Concert Genetics portal.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
	2400	SV101-7	Genetic Testing Unit		Insert the exact GTU or the GTU preceded by "GTU-." For example, insert either: • 6V98G • GTU-6V98G

HEDIS® Guidelines

Deleted *and* ***replaced*** HEDIS Guidelines charts.

Appendix 4-G List of Office-Based Ambulatory Procedures

Added the following procedure codes:

42975	Dise eval slp do brth flx dx
53454	Tprnl balo cntnc dev adjmt

Deleted the following procedure code:

0551T	Tprnl balo cntnc dev adjmt

Appendix 5-A The BlueCard Program

Updated Out-of-State to Other State throughout Appendix 5-A.

Updated BLUEHPN to BlueHPN throughout Appendix 5-A.

Coverage and Eligibility Verification

Added new paragraph about Eligibility and Benefits for BlueHPN EPO Members, below:

Eligibility and Benefits for BlueHPN EPO Members

BlueHPN EPO members will be identified as such within the eligibility and benefits result response. If you are a Blue Shield of California contracted provider within BlueHPN network, submit your claim to Blue Shield. If you are not a contracted BlueHPN provider with Blue Shield of California, you should be aware that the only services that are covered for BlueHPN EPO members are urgent and emergent care outside of BlueHPN product areas. Benefits are determined by Blue plan the member is insured with.

Ancillary Claims Filing Requirements

Deleted *and* ***replaced*** with the following language and ***updated*** the existing table detailing how and where to file claims.

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies (D/HME), Orthotics & Prosthetics (O&P), and Specialty Pharmacy providers. File claims for these providers as follows:

- Independent Clinical Laboratory (Lab)
  - File to the BCBS Plan in whose service area the referring provider is located.
- Durable/Home Medical Equipment and Supplies (D/HME) and Orthotics & Prosthetics (O&P)
  - File to the Plan in whose service area the equipment/supplies was shipped to or purchased at a retail store.
- Specialty Pharmacy
  - File to the Plan in whose service area the ordering physician is located.

If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

Types of Medicare Advantage Plans

Deleted the following bullet point in the list of Medicare Advantage PFFS characteristics:

- You can determine the Terms and Conditions related to a members' Medicare Advantage Plan by accessing the Medicare Advantage Plan Terms and Conditions Lookup Tool located under the Find BlueCard Program Resources link on the BlueCard Program page at blueshieldca.com/provider. To use the tool, enter the first three characters of the member's identification number on the Blue Cross Blue Shield Medicare Advantage PFFS card and click "GO" to view the BCBS Medicare Advantage PFFS Plan's Terms & Conditions.

Medicare Advantage Medical Savings Account (MSA)

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

A Medicare Advantage MSA plan is made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills

Deleted *and* ***replaced*** the Medicare Advantage Network Sharing section with below:

Medicare Advantage PPO Network Sharing

What is BCBS Medicare Advantage PPO Network Sharing?

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted MA PPO provider.

What does the BCBS Medicare Advantage (MA) PPO Network Sharing mean to me?

If you are a contracted MA PPO provider with Blue Shield and you see MA PPO members from other BCBS Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Shield contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with Blue Shield of California and you provide services for any BCBS MA members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a MA PPO member when their member ID card has the following logo.

The "MA" in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Do I have to provide services to Medicare Advantage PPO members from other Blue Cross Blue Shield Plans?

If you are a contracted Medicare Advantage PPO provider with Blue Shield of California, you must provide the same access to care as you do for Blue Shield MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local Blue Cross Blue Shield Medicare Advantage PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

What will I be paid for providing services to these out-of-area Medicare Advantage PPO network sharing members?

If you are a MA PPO contracted provider with Blue Shield, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, Blue Shield will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to Medicare Advantage out-of-area members not participating in the Medicare Advantage PPO Network Sharing?

When you provide covered services to other BCBS MA out-of-area members', benefits will be based on the Medicare allowed amount. Once you submit the claim, Blue Shield will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.

May I request payment upfront?

Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, co-payment, coinsurance, and non-covered services).

Under certain circumstances when the member has been notified in advance that a service will not be covered, you may request payment from the member before services are rendered or billed to the member. The member should sign an Advance Benefit Notification (ABN) form before services are rendered in these situations.

What is the member cost sharing level and co-payments?

Member cost sharing level and co-payment is based on the member's health plan.
You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at (800) 676-BLUE (2583).

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact Blue Shield at (800) 622-0632.

What is BCBS Medicare Advantage PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO BCBS Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted MA PPO provider. MA PPO shared networks are available in 39 states and one territory:

Alabama	Kentucky	Nebraska	Puerto Rico
California	Kansas	Nevada	Rhode Island
Colorado	Louisiana	New Hampshire	South Carolina
Connecticut	Maine	New Jersey	Tennessee
Florida	Massachusetts	New Mexico	Texas
Georgia	Michigan	New York	Utah
Hawaii	Minnesota	Ohio	Virginia
Idaho	Missouri	Oklahoma	Washington
Illinois	Montana	Oregon	Wisconsin
Indiana	North Carolina	Pennsylvania	West Virginia

Removed entire Medicare Advantage SNP Section.

Added Medicare Advantage Coordination of Care Program section, as follows:

Medicare Advantage Coordination of Care Program

A new national Coordination of Care program to support Blue MA members was launched on January 1, 2020. The program aims to increase the quality of members' care by enabling Blue MA PPO group members to receive appropriate care, wherever they access care.

To better support all Blue MA PPO group members residing in California, Blue Shield is working with providers to improve these members' care through:

- Supporting providers with additional information about open gaps in care
- Requesting medical records to give Plans a complete understanding of member health status

MA PPO group members participating into this program can be identified as having a member address in California and based on the following logo included on their Blue Cross and/or Blue Shield ID Cards:

MA | PPO
MEDICARE ADVANTAGE

What does this new program to support Blue Medicare Advantage members mean to me?

This program will result in some changes, including a number that will be beneficial to you, your practice and your patients. The program serves all MA PPO group members that reside in Blue Shield's service area, and some of the benefits that you may see include:

- You will receive consolidated information on gaps in care and risk adjustment gaps, as well as medical record requests for all Blue MA PPO members enrolled with Blue Shield and other Blue Plans and residing in California through local communication practices.
- The MA PPO group members that you see may come into your practice setting more frequently for care due to Blue Shield's requesting care gap closures, allowing for greater continuity in care.

Reminder: As outlined in your contract with Blue Shield, you are required to respond to requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. This includes requests from Blue Shield related to this program.

Health Insurance Marketplaces Overview

Removed section on OPM Multi State Plan Program.

Appendix 5-B Other Payor Summary List

Updated 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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