601 12th Street
Oakland, CA 94607

October 13, 2023

Subject: **Notification of January 2024 Updates to the Blue Shield *Independent Physician and Provider Manual***

Dear Provider:

Blue Shield is revising the *Independent Physician and Provider Manual* (Manual). The changes in each provider manual section listed below are effective January 1, 2024.

On that date, you can search and download the revised manual on Provider Connection at www.blueshieldca.com/provider in the *Provider Manuals* section under *Guidelines & resources*.

You may also request a PDF version of the revised *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 included by reference 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 2024 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

Updates to the
January 2024 *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

Fraud, Waste, and Abuse

Added the website for Medicare beneficiaries to report complaints, using the MEDIC Complaint Form, as follows:

www.qlarant.com/wp-content/uploads/2020/11/Qlarant_I-MEDIC_Complaint_Form_2020_11_04.pdf.

Blue Shield's Code of Conduct and Corporate Compliance Program

Revised entire section detailing the Code of Conduct Corporate Compliance Program and its commitment to requiring compliance with the law and our policies, helping us keep sight of our values and translating our values into everyday actions.

Section 2: Provider Responsibilities

Administrative Compliance

Provider Certification

Reporting Provider Status Changes

Updated in boldface type below, language indicating administrative changes that the provider group or practice is required to notify Blue Shield of, in compliance with the DMHC SB 137 filing:

- Demographic/Administrative Changes

The provider or medical group must notify Blue Shield of demographic or administrative changes as soon as possible for timely directory updates. Examples of these types of demographic or administrative changes include **panel status**, office location, office hours, office email, telephone numbers, fax numbers, billing address, tax identification number, board status, key contact person, etc.

In accordance with state law, all providers and medical groups must notify Blue Shield within five business days when a provider either ceases or resumes accepting new patients.

Provider Directory

Added section entitled "Provider Directory" which explains the procedure for contracted providers to update their provider directory data and attest to accuracy of their data that will display in the Blue Shield *Find a Doctor* online directory. This section was previously listed as a bullet point in the General Administrative Criteria section.

Credentialing and Recredentialing

Specialty Credentialing Specifications

Added the following specialty description for nurse practitioners:

Nurse Practitioners (NP)

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

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

Added the following specialty description for mental health and substance use disorder providers:

Mental Health and Substance Use Disorder Providers

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

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

Home-Based Palliative Care Program Providers

Enrolling/Disenrolling Members in the Home-Based Palliative Care Program

Updated language explaining how providers are responsible for assessing whether a member qualifies for the Home-Based Palliative Care Program after a referral has been made, as follows:

Assessing/Enrolling a Member

Home-based Palliative Care Program providers are responsible for assessing whether a member qualifies for the program after a referral has been made. The assessment must be completed within three (3) business days of the receipt of the referral or, in the case of a hospitalized member, within three (3) days of the member’s discharge from the hospital The

referral will be sent the provider via secure email. Upon receipt, the provider is asked to acknowledge that the email has been received and reviewed. Reply ALL when confirming receipt of the initial email. Once acknowledged the provider can proceed with the outreach and engagement process to schedule an assessment/initial evaluation.

Clarified the time frame for notification of enrollment into the Home-Based Palliative Care Program, in boldface type below:

Enrolling a Member

A notification of enrollment must be emailed to the Blue Shield emails listed below within three (3) **business** days of a member's enrollment, as further described in the agreement.

Added the following bullet points to a list of types of information that the Enrollment Notification must contain:

Enrollment Notification must contain the following information:

- AD & POLST Status
- Is the member enrolling in hospice? (yes/no)

Updated the following language, explaining how a provider can refer a member to the Home-Based Palliative Care Program, in boldface type:

A provider can recommend a member who they feel may benefit from the Program and/or fall under the "Other" category on the Eligibility Screening Tool, by submitting supporting clinical documentation for review **before the member is enrolled in the program**. Providers should complete an eligibility screening tool and submit, along with any other clinical documentation supporting the members diagnosis to BSCPalliativeCare@blueshieldca.com. The member will be reviewed for eligibility by a Blue Shield Clinical Program Manager **who will notify you if the member is appropriate for enrollment in the program.**

Updated language detailing the process for disenrolling a member, as follows:

Disenrolling a Member

Blue Shield must be notified of a member's disenrollment from the program within three (3) business days of the member's disenrollment, as specified in the agreement, via email sent to BSCPalliativeCare@blueshieldca.com. In addition to the information submitted upon disenrollment, the provider is also required to include the reason for the program member's disenrollment from the palliative care program.

- Disenrollment Notification must contain the following information:
- Member's Blue Shield of California Subscriber ID number
- Member First Name
- Member Last Name
- Member DOB
- Disenrollment Date
- Disenrollment Reason
- Advance Directive status at discharge:
- POLST filing status at discharge

Engaging the Palliative Care Team

Added the following language in boldface type below:

It is the program expectation that the palliative care team visit members monthly. These visits can be completed by video, phone, or face to face.

It is required that a Blue Shield Clinical Program Manager attend monthly IDT meetings to discuss currently enrolled patients. It is the responsibility of the provider to schedule the IDT meetings and send invites to the assigned Blue Shield Clinical Program Manager. You will be required to submit monthly clinical documentation for all currently enrolled members. Please submit the clinical documentation to: BSCPalliativeCare@blueshieldca.com **and your assigned Clinical Program Manager.**

Quality Review Guidelines

Added the following reports to the bi-monthly and quarterly review process:

- Enrollment/Disenrollment Report: Providers will complete the enrollment/disenrollment report (sent on a bi-monthly basis). Providers have 7 days to submit the completed report to Blue Shield Palliative Care team.
- Utilization Report: Providers will receive a Utilization Report (sent on a quarterly basis) which will include Emergency Room Visits and Inpatient Hospital Admissions for your review, to assist with identification of potential over-utilization.

Added the following item #6 to list of Quality areas of focus:

Quality Areas of Focus

6. Hospice Transitions, when appropriate

Service Accessibility Standards

Behavioral Health Appointment Access Standards

Added access standard for initial routine visits, as follows:

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

Language Assistance for Persons with Limited English Proficiency (LEP)

Updated this section to include the following NCQA requirements:

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

Provider Appeals and Dispute Resolution

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

Provider Appeals of Medicare Advantage Claims

Non-Contracted Providers

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

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

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

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

To appeal the provider organization's decision upholding initial payment, the provider must submit a written request to:

Blue Shield of California
Medicare Provider Appeals Department
P.O. Box 272640
Chico, CA 95927

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

Medicare Part D

Exclusion Lists

Updated website listing the General Services Administration (GSA) database of excluded individuals/entities to www.sam.gov.

Medicare Part D

Medicare Part D Prescriber Preclusion List

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

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

Medicare Part D

Medication Therapy Management Program (MTMP)

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

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

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

Blue Shield Medicare (PPO) (Medicare Advantage)

Blue Shield Medicare (PPO) Benefits

Updated language detailing vision services benefits, as follows:

Vision Services

Blue Shield Medicare (PPO) individual and group plans cover vision services that meet Medicare guidelines.

In addition to Medicare-covered services, all Blue Shield Medicare (PPO) individual and some group plans cover routine (non-Medicare covered) eye examinations/screenings. For individual and group plans, services are provided through VSP Vision Care. Refer to the Blue Shield Medicare (PPO) Summary of Benefits for benefit guidelines.

Care Management

Maternity Management

Added per SB 1207, Health & Safety Code section 1367.625 (Maternal Mental Health), language detailing the clinical referral for the maternity program, as follows:

Providers can refer members to Magellan by calling Customer Service at (877) 263-9952 or request a clinical referral form at BSCClinicalLiaison@MagellanHealth.com.

Additional Care Management Program Descriptions

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

Appendices

Appendix 4-C CMS 1500 General Instructions

Updated the following instructions, as follows:

9c Reserved for NUCC Use

Leave blank.

15 Other Date

If applicable, enter another date related to the patient's condition or treatment. Enter the date in the 8-digit (MM/DD/YYYY) format.

Enter the applicable qualifier to identify which date is being reported.

454 Initial Treatment

304 Latest Visit or Consultation

453 Acute Manifestation of a Chronic Condition

439 Accident

455 Last X-ray

471 Prescription

090 Report Start (Assumed Care Date)

091 Report End (Relinquished Care Date) 4

444 First Visit or Consultation

Appendix 4-F List of Office-Based Ambulatory Procedures

Added the following office-based ambulatory procedure codes:

	Description
C7513	Cath/angio dial cir w/aplasty
C7514	Cath/angio dial cir w/stents
C7515	Cath/angio dial cir w/embol

Appendix 5-A The BlueCard® Program

Updated "out-of-state" to "other state," throughout Appendix 5-A.

Products Included in the BlueCard Program

Removed the "Medigap" bullet-point from the list of products that the BlueCard Program offers.

Three-Character Prefix

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

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue plan to which the member belongs. It is critical for confirming a patient's membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card and pass this key information to your billing staff. Do not make up prefixes.

As a provider serving other state Blue plan members, you may find the following tips helpful:

- Ask the member for his or her most current Blue ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in your patient's file.
- Member IDs must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID.

Medical Records Requests and Processing

Updated the following bullet point in list of steps that Blue Shield takes to ensure delivery of medical record requests and processing:

- When providers respond to requests and submit medical records to us, we ensure that all records are sent electronically to the member's Blue plan within three business days of their receipt, please include the medical records request letter with all supporting documentation.

BlueCard Claim Tips

Updated the following bullet point in list of tips providers can use to improve their claims experience:

- If medical records are requested, send them to the claims address listed on the request letter you received from Blue Shield.

Added instructions for providers to access the online Chat feature at blueshieldca.com/provider for questions about BlueCard claims.

Submitting BlueCard Claims

Removed the EDI inquiry form and EDI email address as a means to inquire about claims. All questions about electronic claims submission should be directed to the Blue Shield EDI Help Desk at (800) 480-1221.

Medical Records

Updated the list methods to assist in timely processing of medical records in boldface type below:

Helpful Ways You Can Assist in Timely Processing of Medical Records

- If the records are requested following submission of the claim, forward all requested medical records **and a copy of the medical records request letter**, to Blue Shield's dedicated BlueCard Customer Service team at: Blue Shield of California, BlueCard Program, P. O. Box 272630, Chico, CA 95927-2630.
- Include the **medical records request** letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Blue Shield.

Provider Claim Appeals

Added the following language detailing how to submit an online claim appeal:

You now have the option to submit a claim appeal online, in addition to using the existing mail-in process.

How it works

You will need the claim number to get started:

- Log in to your account on Provider Connection at blueshieldca.com/provider/account-tools/login/home.sp, search for a claim, then from the *Claim* page, click the *Resolve claim issue or dispute* link at the top of the page, or
- If you already know the claim number, log in and enter it on the *Claim issues & disputes* page at blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/claims/pdr/claim-issues.

Appendix 5-B Other Payor Summary List

This appendix was ***removed*** from the manual. It can be found on the Provider Portal at blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/policies_standards/other_payor_summary_list where it is updated monthly.