April 22, 2022

Subject: **Notification of July 2022 Updates to the Blue Shield *HMO IPA/Medical Group Procedures Manual***

Dear IPA/medical group:

We have revised our *HMO IPA/Medical Group Procedures Manual.* The changes listed in the following provider manual sections are effective July 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 manuals be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *HMO IPA/Medical Group Procedures Manual* is referenced in the agreement between Blue Shield of California (Blue Shield) and those IPAs and medical groups contracted with Blue Shield. If a conflict arises between the *HMO IPA/Medical Group Procedures Manual* and the agreement held by the IPA or medical group and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the July 2022 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships & Network Management

T12565 (4/22)

UPDATES TO THE JULY 2022
HMO IPA/MEDICAL GROUP PROCEDURES MANUAL

Section 2.8 Benefits and Benefit Programs

CARE MANAGEMENT

Added *the following section describing Blue Shield's new maternity program:*

Maternity Program. Blue Shield has teamed up with Maven to offer Maven Maternity to our members. Maven Maternity is a 24/7 virtual care program designed to support Blue Shield members during and after pregnancy. Maven is also available to members who have experienced a pregnancy loss and to partners if they are on an eligible Blue Shield medical plan. Blue Shield members can use Maven to book coaching and educational video appointments with providers across more than 30 specialties, including OB-GYNs, mental health specialists, doulas, lactation consultants, and more. Providers can encourage members to enroll in the Maven Maternity Program by visiting blueshieldca.com/maternity.

PHARMACEUTICAL BENEFITS

Drug Formulary

Added *language in boldface type below:*

For drugs that require prior authorization or an exception to benefit or coverage rules, coverage decisions are based on the medication coverage policies approved by Blue Shield's P&T Committee and the following will be considered during the review for coverage:

1. The requested drug, dose, and/or quantity are safe and medically necessary for the specified use.
2. Prior use of formulary alternative(s) have not achieved therapeutic goals or are inappropriate for the specific member's situation.
3. Treatment is stable and a change to an alternative treatment may cause clinical decompensation or immediate harm.
4. Relevant clinical information provided with the authorization request supports the use of the requested medication over formulary drug alternatives. **This includes:**
    a. **Formulary drugs alternatives are expected to be ineffective or are likely or expected to cause an adverse reaction or physical or mental harm based on the characteristics of the member's known clinical characteristics and history of the member's prescription drug regimen.**
    b. **Formulary drug alternatives are not clinically appropriate because they are expected to do any of the following:**
        i. **Worsen a comorbid condition.**
        ii. **Decrease the capacity to perform daily activities.**
        iii. **Pose a significant barrier to adherence or compliance.**

Pharmaceuticals in the Medical Benefit

Added *new language below to support AB 347:*

For drugs that require prior authorization or an exception to step therapy requirements, coverage decisions are based on the medication coverage policies approved by Blue Shield's P&T Committee and the following will be considered during the review for coverage:

1. The requested drug, dose, and/or quantity are safe and medically necessary for the specified use.
2. Prior use of step therapy alternative(s) has not achieved therapeutic goals or are inappropriate for the specific member's situation.
3. Treatment is stable and a change to an alternative treatment may cause clinical decompensation or immediate harm.
4. Relevant clinical information provided with the authorization request supports the use of the requested medication over step therapy drug alternative(s). This includes:
    a. Step therapy drug alternatives are expected to be ineffective or are likely or expected to cause an adverse reaction or physical or mental harm based on the characteristics of the member's known clinical characteristics and history of the member's prescription drug regimen.
    b. Step therapy drug alternatives are not clinically appropriate because they are expected to do any of the following:
        i. Worsen a comorbid condition.
        ii. Decrease the capacity to perform daily activities.
        iii. Pose a significant barrier to adherence or compliance.

Section 4.5 Provider Appeals and Dispute Resolution

UNFAIR BILLING AND PAYMENT PATTERNS

Address For Submission of an Initial Appeal

Added *information to learn more about the appeal process and digital submission options, below:*

For additional information regarding the appeal process, and to review digital submission options, please visit Provider Connection at blueshieldca.com/provider.

Section 5.1 Utilization Management

DELEGATION OF UTILIZATION MANAGEMENT

Added *the following to the list of activities that Blue Shield will evaluate during the audit of the IPA/medical group:*

- Adverse determinations with Medical Records
    - With evidence of Board-Certified Reviewer internal and external if applicable
- Approved authorizations with Medical Records
- Pharmacy authorizations with Medical Records
- Cancelled authorizations with Medical Records
- Standing authorizations with Medical Records
- Interrater Reliability, evaluated annually

Removed *the following from the list of audit activities:*

- Case Management Records - if delegated and/or upon request by the health plan

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

IPA/Medical Group Covered Services and Financial Responsibility

Updated *the following IPA/medical group responsibility with additions in boldface type below:*

- Decisions related to delegated medical services. As such, medical services for the treatment of gender dysphoria, eating disorder, or substance use disorder are the responsibility of the IPA/medical group. In making utilization management decisions, the IPA/medical group will **utilize ASAM, LOCUS, CALOCUS, and ECSII for mental health and substance use disorder reviews. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.**

Section 5.2 Quality Management Programs

SERVICE ACCESSIBILITY STANDARDS FOR COMMERCIAL AND MEDICARE

Updated *language in boldface type below:*

ACCESS TO CARE	STANDARD
Urgent Care Appointment Access to urgent symptomatic care appointments requiring prior authorization. **When a Practitioner refers a member (e.g., a referral to a specialist by a PCP or another specialist) for an urgent care need to a specialist and an authorization is required, the member must be seen within 96 hours or sooner as appropriate from the time the referral was first authorized.** The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee.	Within 96 hours

BEHAVIORAL HEALTH APPOINTMENT ACCESS STANDARDS

Deleted and replaced *the chart as follows:*

CATEGORY	ACCESS STANDARDS
Routine and follow-up visits with non-physician practitioners	Within 10 business days
Routine and follow-up visits with behavioral health physicians	Within 15 business days
Urgent Care visits	Within 48 hours
Care for an Emergent Non-Life-Threatening Situation	Within 6 hours

GEOGRAPHIC DISTRIBUTION

Added *the following new standard for Geographic Distribution:*

CATEGORY	STANDARD	COMPLIANCE TARGET
A total of four (4) Non-Physician Medical Practitioners in any combination that does not include more than: • Two (2) Physician Assistants per supervising physician • Four (4) Nurse Practitioners per supervising physician • Three (3) Nurse Midwives per supervising physician	Each Non-Physician Medical Practitioner practicing under a physician increases that physician's capacity by 1,000 members to a maximum of 4,000 additional members. However, the following specification cannot be exceeded: • Physician Assistants: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Physician Assistant 1:2. • Nurse Practitioners: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Nurse Practitioner 1:4. • Nurse Midwives: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Nurse Midwife 1:3.	100%

Appendices

APPENDIX 4-A CLAIMS, COMPLIANCE PROGRAM, IT SYSTEM SECURITY, AND OVERSIGHT MONITORING

IT System Security

Added *the following areas to be reviewed during the IT system integrity audit:*

- Operational effectiveness
- Access to programs and data access rights definition
- Access to programs and data access control mechanisms and password complexity
- Program changes/standard change management
- Computer operations (backup, recovery, and resumption)/HIPAA compliance
- Program changes
- Access to IT privileged functions

APPENDIX 5-A UTILIZATION MANAGEMENT DELEGATION STANDARDS

All references to the Industry Collaboration Effort (ICE) ***have been changed*** *to Health Industry Collaboration Effort (HICE).*

STANDARDS FOR PROGRAM STRUCTURE AND PROCESSES

Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria

Added *the following to UM activities that should be included in UM Program Description or Policies and Procedures:*

- Program description must be organized and written so that staff members and others can understand the program's structure, scope, processes, and information sources used to make UM determinations.

USE OF QUALIFIED PROFESSIONALS IN DECISION MAKING

Updated *the use of qualified professionals with additions in boldface type below:*

- Written procedure for using board-certified **internal and external** consultants to assist in making medical necessity determinations.
    - **Evidence of Board-Certified consultants in making decisions on adverse determinations**

UM DECISION TIMELINESS STANDARDS

Added *the following to both the Commercial and Centers for Medicare & Medicaid Services (CMS) UM Decision Timeliness Standards:*

Web Portal Notification/Provider

If a practitioner web portal is used to provide electronic denial notifications, the entity must:

- Inform practitioners of the notification mechanism and their responsibility to check the portal regularly.
- Document the date and time when the information was posted in the portal.
- Provide alternative notification method for practitioners who do not have web portal access.
- Ensure a process is in place for notifying a practitioner of a denial notification via the web portal.

Web Portal Notification/Member

The organization must document the member's agreement to receive electronic notifications via the web portal. The entity must:

- Document the date and time when the information was posted in the portal.
- Provider notification to members that a new document or update is available in the portal and when it is posted.
- Provide alternative notification method for members who do not have access to the web portal access or do not agree to receive notifications via the web portal.
- Ensure a process is in place for notifying a member of a denial notification via the web portal.

STANDARDS FOR PERSONAL AND HEALTH INFORMATION (PROTECTED HEALTH INFORMATION)

Added *the following new section describing meeting compliance with UM denial controls:*

UM Systems Controls Compliance

At least annually, the organization demonstrates that it monitors compliance with its UM denials controls by:

1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modification.
2. Analyzing all instances of date modification that did not meet the organizations policies and procedures for date modification.
3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.