April 22, 2022

Subject: **Notification of July 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 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 *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 July 2022 version of this manual, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships & Network Management

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UPDATES TO THE JULY 2022
INDEPENDENT PHYSICIAN AND PROVIDER MANUAL

Section 1: Introduction

MEMBER RIGHTS AND RESPONSIBILITIES

Statement of Member Responsibilities

Updated *the following member responsibility with additions in boldface below:*

15. For mental health and substance use disorder services, follow the treatment plans and instructions agreed to by them and Blue Shield's mental health service administrator (MHSA) and obtain prior authorization as required **by the applicable plans *Evidence of Coverage*** *or* ***Health Service Agreement*** for all non-emergency mental health and substance use disorder services. Medical services for the treatment of gender dysphoria, eating disorder or substance use disorder are the responsibility of Blue Shield.

MEMBER GRIEVANCE PROCESS

Added *entire "External Exception Review" section to the Member Grievance Process, below:*

External Exception Review

If Blue Shield denies an exception request for coverage of a Non-Formulary Drug, Step Therapy or a Prescription Drug Prior Authorization, the Member, authorized representative, or the Provider may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. This review process applies to plans regulated by the DMHC or CDI.

Section 2: Provider Responsibilities

SERVICE ACCESSIBILITY STANDARDS FOR COMMERCIAL AND MEDICARE

Updated *language for the Urgent Care Appointment Service Accessibility Standards for Commercial and Medicare, in boldface type:*

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

PROVIDER-TO-MEMBER RATIO

Added *the following new standard for Provider-to-Member Ratio:*

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%

Section 3: Medical Care Solutions

MEDICAL CARE SOLUTIONS PROGRAM OVERVIEW

Added *language to indicate hours of operation for inpatient utilization management, in boldface type below:*

The Medical Care Solutions Department within Blue Shield's Health Solutions division is established to provide oversight of the delivery of care to members. **Medical Care Solutions provides inpatient utilization management 7 days a week from 8 a.m. to 5 p.m., except for company designated holidays.**

PRIOR AUTHORIZATION LIST FOR NETWORK PROVIDERS

Mental Health and Substance Use Disorder

Noted *that the plan's Evidence of Coverage or Health Service Agreement should be referenced in determining if prior authorization is required for Outpatient Mental Health and Substance Use Disorder Services.*

Section 4: Billing

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.

REQUIRED INFORMATION/APPEAL

Added *"bullet point" with information regarding documentation required to accompany submitted appeals, below:*

- Proof of participation in the IPA's provider appeal process and when the original determination was made by the IPA (such as a copy of the IPA Appeal denial letter and/or denial letter EOB), when applicable.

PROVIDER APPEAL DOCUMENTATION

Added *guidance on how to expedite initial dispute processing, below:*

Providing all supporting documentation at the time the initial dispute is submitted will help ensure timely processing.

Section 5: Blue Shield Benefit Plans and Programs

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Blue Shield MHSA Covered Services for Commercial Plan Members

Updated *the following with information regarding services for which MHSA is responsible for prior authorization of paying claims for, with additions in boldface type below:*

~~Other~~ Outpatient Mental Health and Substance Use Disorder Services listed below when provided by a MHSA contracted provider, **as required by the applicable plans *Evidence of Coverage or Health Service Agreement*,** ~~as listed below~~.

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.

Appendix 4-D: CMS 1500 General Instructions

Added *the following language to the instructions for entering Procedures onto a CMS 1500 Form, below:*

24D PROCEDURES, SERVICES, OR SUPPLIES

To report bi-lateral procedures, the services must be billed on two lines of the submitted claim. For example:

19368
19368-50