

Section 3: Medical Care Solutions

Blue Shield Hospital and Facility Guidelines

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Section 3: Medical Care Solutions

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Medical Care Solutions Program Overview

The Medical Care Solutions Program within Blue Shield's Health Solutions division is established to provide oversight of the delivery of care to members. Medical Care Solutions provide inpatient utilization management 7 days a week from 8 a.m. to 5 p.m., except for company designated holidays. The Blue Shield Medical Care Solutions professional staff includes California-licensed clinicians who monitor healthcare services delivered by contracted-physicians and providers for timeliness, appropriateness, and quality of care.

The Blue Shield Medical Care Solutions program consists of active ongoing coordination and evaluation of requested or provided health services to promote delivery of medically necessary, appropriate health care or services and quality, cost-effective clinical outcomes. The Medical Care Solutions Program is designed to assist Blue Shield contracted physicians, providers, and hospitals in ensuring the coverage of medically necessary services.

Blue Shield has developed Medical Care Solutions processes that address inpatient and outpatient utilization, as well as monitor quality of care. Medical Care Solutions processes include, but are not limited to, the following functions:

- Prior authorization/elective admission authorization
- Prior authorization of services
- Emergency services review
- Transplant management
- Utilization management (UM)/concurrent and retrospective review (post-service review)
- Medical Care Solutions for continuity and coordination of care
- Focused ambulatory care review
- Identification and referral of potential quality-of-care issues
- Clinical claims review
- Facility claims review
- Provider compliance review
- Review of high dollar cases

Blue Shield Medical Care Solutions will follow regulatory and accreditation Timeliness Standards for all urgent and non-urgent requests for services. Blue Shield will also send written notification to the member and providers to confirm the request determination. Blue Shield licensed case managers engage with members to ensure care needs are coordinated prior to and after a hospital confinement.

Members may self-refer or be referred to Medical Care Solutions Case Management through a variety of sources, including their physician, Social Services, family members, employers, etc.

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Medical Necessity

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 and/or evidenced based clinical guidelines;
- 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.

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Medical Necessity *(cont'd.)*

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

The goal of the Blue Shield Medical Care Solutions Program is to promote the efficient and appropriate utilization of medical services and to monitor the quality of care given to members. To accomplish this goal, the program requires systematic monitoring and evaluation of the medical necessity and level of care of the services requested and provided. Blue Shield determines medical necessity and the appropriateness of the level of care through the prospective review of care requested and the concurrent and retrospective review of care provided. These reviews are conducted by Blue Shield clinicians, medical directors, pharmacists, peer review committees, physician peer reviewers, and other consultants.

Blue Shield may also delegate utilization management (UM) activities to subcontracted entities. Blue Shield approval of the delegated entity's UM program is based on a review of its policies and procedures, demonstration of compliance with stated policies and procedures, and the ability to provide services to our members in keeping with various accreditation and regulatory requirements. All delegated activities are monitored and evaluated by the Blue Shield Health Care Quality and Affordability teams and the appropriate oversight committee to assist the delegated entity in improving its processes. Blue Shield retains the authority and responsibility for the final determination in UM medical necessity decisions and ensures appeals related to utilization issues are handled in a timely and efficient manner.

Medical necessity reviews (for both authorizations and non-authorizations) made by Blue Shield use a hierarchy of criteria. (The specific hierarchy can be found in the Utilization Management Program Description.) These criteria include internal medical policies established by the Blue Shield Medical Policy Committee, nationally recognized evidence-based criteria and guidelines, MCG, National Imaging Associates (NIA) Radiology Clinical Guidelines, Advisory Committee on Immunization Practices (ACIP), and Medication Policies (for non-self-administered drugs such as Injectable and Implantable drugs) established by the Blue Shield Pharmacy & Therapeutics Committee (these criteria and guidelines are adopted with input from network physicians and are regularly reviewed for clinical appropriateness). Where applicable, criteria established by the Center for Medicare & Medicaid Services (CMS) and DME coverage criteria are utilized. IPA/medical groups must use the most current version of the policies and manage updates to their UM review processes. These policies may be found on Provider Connection at blueshieldca.com/provider and may be updated quarterly as needed.

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). 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.

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UM Criteria and Guidelines *(cont'd.)*

Blue Shield's Medical Care Solutions Department is structured to ensure utilization management decision-making is based only on the appropriateness of care and service and existence of benefit coverage. The Medical Care Solutions Program ensures that contracting physicians are not penalized for authorizing appropriate medical care. Blue Shield does not specifically reward practitioners or providers or other individuals for issuing denials of coverage or service of care. Medical decisions are made by qualified individuals, without undue influence from management concerned with Blue Shield's fiscal operations. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Medical Necessity Denials

The Blue Shield Chief Health Officer has overall responsibility for Blue Shield's Medical Care Solutions Program. The Blue Shield Senior Medical Director in Medical Care Solutions along with other Blue Shield Medical Directors are responsible for the implementation and providing clinical expertise of the Medical Care Solutions program. A licensed physician reviews all medical necessity denials; licensed pharmacists review medical necessity for pharmaceuticals/drugs and place of administration covered in the medical benefit. Board-certified physicians from the appropriate specialty assist in making medical necessity determinations, as needed.

When a hospital admission, continued stay, pharmaceutical/drug, or proposed service is determined to be not medically necessary or not covered under the member's plan, the facility / attending physician is notified by phone or fax within 24 hours of the decision. Written notification of the denial is also sent to the member or responsible party, the attending physician, and the hospital. Notification for routine pre-service requests is within two business days of making the decision. For urgent requests, notification is within 72 hours of receipt of requests.

Per your Blue Shield contract, if authorization for services in an outpatient or inpatient hospital facility or an extension of days is required and not obtained or is denied by Blue Shield, neither Blue Shield nor the member is financially responsible for the denied days. The member may be held financially responsible only if the hospital obtains in writing an acknowledgment of financial liability from the member or responsible party prior to rendering the service. This acknowledgment must be specific to the admission or days denied by Blue Shield.

Blue Shield Medicare Advantage plan members are held financially responsible for any denied services received, only in accordance with federal Centers for Medicare & Medicaid Services (CMS) regulations. Prior to the member's time of discharge, if the member disagrees with the decision to discharge or the hospital is not discharging the member, but the Health Plan or delegated IPA/medical group will no longer continue coverage of the inpatient hospital stay, the member must receive the CMS-required "Notice of Discharge Medicare Appeal Rights" (NODMAR) no later than the day before hospital coverage ends. A member is entitled to coverage until at least noon of the day after such notice is provided. The member or member representative must sign the letter or the hospital must document that the member refused to sign the letter. Copies of the letter must be maintained in the member's medical record for auditing purposes.

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Blue Shield Medical & Medication Policies

Medical and medication policies are general statements of coverage for Blue Shield as a company. Unless a specific regulatory requirement (state or federal) or a plan-specific benefit or limitation applies, medical and medication policies are applied to individuals covered by Blue Shield.

The emergence of new technologies and pharmaceuticals (or new uses for existing technologies and pharmaceuticals) is monitored on an ongoing-basis to ensure timely availability of appropriate policies.

Medical Policy

The Blue Shield Medical Policy Committee reviews technologies (devices and/or procedures) for medical and behavioral health indications that are new or emerging, and new applications for existing technologies. The Committee meets at least four times per year. Experts are consulted and invited on an as-needed basis to the Committee.

The primary sources of the technology evaluations are derived from the Blue Cross Blue Shield Association (BCBSA) Evidence Street, the Blue Cross Blue Shield Association Medical Policy Reference Panel (BCBSA MPP), and the California Technology Assessment Forum (CTAF).

For a recommended technology to be considered eligible for coverage, that technology must meet all of the Technology Assessment (TA) Criteria:

1. The medical technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effectiveness of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as established alternatives.
5. The improvement must be attainable outside investigational settings.

Medication Policy

The Blue Shield Pharmacy and Therapeutics (P&T) Committee reviews pharmaceuticals. Pharmaceutical reviews are conducted using the available scientific evidence, including randomized controlled trials, cohort studies, systematic reviews, and the clinical trial data submitted to the FDA to support a new drug, abbreviated new drug, or biologic license application (NDA, ANDA, BLA).

For a pharmaceutical to be considered eligible for coverage, the drug product must meet the following criteria:

1. The pharmaceutical product is approved by the U.S. Food and Drug Administration for marketing in the U.S.
2. The scientific evidence must permit conclusions concerning efficacy and safety of the pharmaceutical product on health outcomes.
3. The available scientific evidence demonstrates improved net health outcomes, and the beneficial effects outweigh the harmful effects on health outcomes.
4. The pharmaceutical improves net health outcomes as much as, or more than the established alternatives.
5. The health outcome improvements are attainable outside of investigational settings.

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Blue Shield Medical and Medication Policies *(cont'd.)*

Medication Policy *(cont'd.)*

Only when sufficient credible evidence (such as clinical studies and trials, peer review scientific data, journal literature) has demonstrated safety and efficacy, will a technology or pharmaceutical be considered eligible for coverage, based on medical necessity.

Note: Benefit and eligibility criteria supersede medical necessity determinations.

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 which may require step therapy. 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 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.

Medical and Medication policy information is available on Provider Connection at blueshieldca.com/provider under *Authorizations*, and then *Clinical policies & guidelines*. If questions arise about Blue Shield medical or medication policy or you require specific guidelines, please contact Provider Information & Enrollment at (800) 258-3091.

For information concerning the Blue Shield member grievance process, please refer to Section 1 of this manual.

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Admission Authorization

Prior Authorization/Elective

The physician or hospital must obtain authorization (when applicable) for Blue Shield member hospital admissions from the designated Medical Care Solutions team five days prior to an elective admission. If prior authorization is not required, the physician or hospital must notify the Medical Care Solutions team at time of admission. Providers can now submit authorization requests online. Requests can be submitted for authorization directly to Blue Shield for any of the following services: inpatient hospital, outpatient services, home health care/home infusion services, residential, and DME/orthotics services. Simply go to Provider Connection at blueshieldca.com/provider and click on *Authorizations*. Enter necessary information and you will receive a response back in your message center advising of the status of your authorization request. Authorizations can be submitted electronically to Blue Shield. For specific guidelines, refer to Blue Shield's 837 Companion Guide found on Provider Connection.

Additional information such as operative reports or progress reports that support the authorization can be faxed to Blue Shield. Please include a coversheet containing all the necessary information included.

Hospitals can also call the number on the member's identification for prior authorization. Generally, for PPO products, the request for admission authorization is referred to Blue Shield or a third-party review organization. For Access+ HMO and Blue Shield Medicare Advantage (HMO), Blue Shield generally delegates the responsibility for administering the UM program to a contracted IPA/medical group; however, both the IPA/medical group and Blue Shield's Medical Care Solutions department are to be notified of the hospital admission. The designated primary care physician is responsible for coordinating the member's care and ensuring that appropriate authorizations are provided. For the Access+ Point of Service (POS) product, the UM responsibility may be contingent upon the type of benefit the member is seeking (i.e., HMO or opt-out). For example, if a POS member chooses the opt-out feature, the primary care physician is not involved, and Blue Shield Medical Care Solutions will review the authorization request.

In any event, including the absence of the member's card, the Blue Shield eligibility telephone lines will direct callers to the designated Medical Care Solutions team (i.e., the IPA/medical group or Blue Shield) and the appropriate telephone number to call for authorization.

Blue Shield members are also advised in their Summary of Benefits and *Evidence of Coverage* (EOC) that they are responsible for obtaining or assuring that their physicians (attending or specialist) obtain prior authorization from the designated Medical Care Solutions team for specified services.

Note: If hospital fails to obtain authorization prior to providing covered services to a member, as required, or if hospital provides services outside of the scope of the authorization obtained, then Blue Shield, or its delegate shall have no obligation to compensate hospital for such services; hospital will be deemed to have waived payment for such services and shall not seek payment from Blue Shield, its delegate, or the member.

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Admission Authorization *(cont'd.)*

Ambulatory Surgeries/Procedures

Facility-based ambulatory surgeries/procedures are performed in an acute care facility on an outpatient basis or in an ambulatory surgery center. Surgical diagnostic procedures are identified as facility-based ambulatory surgeries/procedures. Unless Blue Shield and the IPA/medical group have contracted differently, Blue Shield authorization is required for facility-based ambulatory surgeries/procedures.

Office-based ambulatory surgeries/procedures (minor procedures) should be performed in a physician office setting. If it is medically necessary that they be performed in a facility setting, on an outpatient or inpatient basis, notification to Blue Shield Medical Care Solutions is required. If an IPA or medical group schedules an office-based surgery/procedure in an outpatient facility setting, the hospital should confirm that the IPA provided notification to Blue Shield Medical Care Solutions.

With the exception of fully capitated IPA/medical groups, all other IPA/medical groups must notify Blue Shield of any authorized ambulatory surgeries via submission of an authorization log.

A list of frequently performed office-based ambulatory surgeries/procedures (minor procedures) can be found in the Appendix 4-E of this manual or obtained electronically from your Blue Shield Network Manager.

Emergency Services

Prior authorization is not required for urgent and emergency services. If these services result in a hospital inpatient admission, the attending physician or the hospital must notify the designated Medical Care Solutions team within 24 hours of that admission. Medical Care Solutions notifies the members identified PCP of admission within 24 hours. The member should notify his or her primary care physician (HMO) as soon as it is medically possible for the member to provide notice.

Note: Failure to comply may result in non-coverage for the services and/or greater out-of-pocket expense for PPO members.

Notification of hospital admission is required within 24 hours. The designated Medical Care Solutions team reviews the request for admission within one day from the receipt of request and notifies the facility of the determination by phone, fax and/or in writing of the decision. Admissions are reviewed for medical necessity, level of care, appropriateness of care, and benefit determination. The hospital, member, and attending physician are also notified in writing of the determination, including the initial authorized length of stay or denial of the authorization request.

Discharge Date Notification

For all inpatient stays, the hospital/facility must notify Blue Shield's Medical Care Solutions department via fax at (844) 295-4639 of a patient's discharge date and disposition within 24 hours of the member's discharge.

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Admission Authorization *(cont'd.)*

Outpatient Authorizations

TYPE OF SERVICE / PROCEDURE	ALL LINES OF BUSINESS
<p>Ambulance Service</p> <p><u>Non-Emergency:</u> Blue Shield covers non-emergency ambulance services using our contracted providers. Non-emergency ambulance requires prior authorization.</p> <p>Non-emergency ambulance (surface and air) services may include transferring a member from a non-contracted facility to a contracted facility, or between contracted facilities, in connection with an authorized confinement/admission, and under other circumstances as necessary, if medical treatment or observation is required.</p> <p><i>Note: Non-Emergency services provided solely for the convenience of the patient or physician would not be covered.</i></p>	<p>For PPO, Direct Contract HMO, or HMO members:</p> <p>Go to Provider Connection at blueshieldca.com/provider and click on <i>Guidelines & resources, Patient care resources</i>, then <i>Ancillary provider rosters</i> to view a list of contracted ambulance providers or call Provider Information & Enrollment at (800) 258-3091 for information on contracted options.</p>

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Admission Authorization *(cont'd.)*

Outpatient Authorizations *(cont'd.)*

TYPE OF SERVICE / PROCEDURE	ALL LINES OF BUSINESS
<p>Mental Health and Substance Use Disorder</p> <p>For commercial plans managed by Blue Shield's mental health service administrator (MHSA). This includes fully-insured HMO, PPO, EPO, and self-funded plans.</p> <p>Prior authorization is required for:</p> <ul style="list-style-type: none"> • Non-emergency mental health or substance use disorder Hospital admissions, including acute and residential care • Outpatient Mental Health and Substance Use Disorder Services listed below, as required by the applicable plan's <i>Evidence of Coverage or Health Service Agreement</i>: <ul style="list-style-type: none"> ○ Behavioral Health Treatment (BHT) including Applied Behavior Analysis (ABA). ○ Electro-convulsive Therapy (ECT) and associated anesthesia. ○ Intensive Outpatient Program. ○ Partial Hospitalization Program. ○ Neuropsychological Testing should be considered for coverage through the patient's mental health benefit when: <ul style="list-style-type: none"> • 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). ○ Transcranial Magnetic Stimulation. <p>For Blue Shield Medicare Advantage Plans managed by Blue Shield's mental health service administrator (MHSA).</p> <p>Prior authorization is required for:</p> <ul style="list-style-type: none"> • Inpatient admissions • Partial hospitalization programs • Intensive outpatient programs • Office Based Opioid Treatment • Other Outpatient • Residential Treatment 	<p>Contact MHSA (800) 378-1109</p> <p>Contact Blue Shield Medical Care Solutions (800) 541-6652 Option 6</p> <p>or Fax: (844) 696-0975</p> <p>or online by going to blueshieldca.com/provider under <i>Authorizations, Authorization tools</i>, then <i>Request a medical authorization</i>.</p>

Section 3: Medical Care Solutions

Admission Authorization *(cont'd.)*

Outpatient Authorizations *(cont'd.)*

TYPE OF SERVICE / PROCEDURE	ALL LINES OF BUSINESS
<p>Radiology /Radiotherapy</p> <p>Radiology services for a given geographic area may be directed to specific providers. The process may differ depending upon the network structure in an individual geographic area or for procedures managed by NIA.</p> <p>For PPO and Direct Contract HMO members, no prior authorization is required, except for procedures managed by NIA.</p> <p>The following radiologic procedures are managed by National Imaging Associates, Inc. (NIA):</p> <ul style="list-style-type: none"> • CT, All Examinations • MRI/MRA, All Examinations • Nuclear Cardiology Imaging • PET (Positron Emission Tomography) <p>Select radiology services provided to members in HMO and Blue Shield Medicare Advantage plans continue to be reviewed by Blue Shield Medical Care Solutions. Prior authorization may be required.</p>	<p style="text-align: center;">Submit authorization requests online at www.RadMD.com or contact NIA at (888) 642-2583</p>
<p>FDA-Approved Prescription Pharmaceuticals/Drugs</p> <p>FDA-approved prescription pharmaceuticals/drugs provided as part of a medical service and administered in the physician office, outpatient facility, ambulatory infusion center, or through home health/home infusion. (Does not apply to drugs or products that are excluded from the member's benefit.)</p>	<p>A complete list of medications and their authorization requirements for coverage in the medical benefit can be found on Provider Connection at blueshieldca.com/provider under <i>Authorizations, Clinical policies & guidelines</i>, then <i>Medication policy</i>.</p> <p>Faxed requests must be submitted on the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016).</p> <p>Providers may also submit prior authorization requests online by going to blueshieldca.com/provider under <i>Authorizations</i> then <i>Request a medical authorization</i>.</p> <p>An additional link to the <i>Medication Policies User Guide</i> is available on the <i>Medication Policy</i> homepage.</p> <p>Contact Blue Shield Medical Care Solutions (800) 541-6652 Option 6</p> <p style="text-align: center;">or</p> <p style="text-align: center;">Fax: (844) 262-5611</p> <p style="text-align: center;">or</p> <p>Submit online, with attached documentation, via AuthAccel in the <i>Authorizations</i> section of Provider Connection at www.blueshieldca.com/provider.</p>

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Organ and Bone Marrow Transplants

Members referred for major organ and bone marrow transplants (excludes cornea, kidney only and skin) are evaluated within the Blue Shield Major Organ/Bone Marrow Transplant Network. Certain transplants are eligible for coverage within Blue Shield's transplant network if specific criteria are met and prior written authorization is obtained from Blue Shield's Medical Care Solutions Transplant Team. Only the human organ and bone marrow transplants listed below are covered. For commercial HMO and PPO members, donor costs for a member are only covered when the recipient is also a Blue Shield member. Donor costs are paid in accordance with Medicare coverage guidelines for Blue Shield Medicare Advantage plan members.

All transplant referrals must be to an approved network transplant facility for benefits to be paid. Contact the Blue Shield Transplant Team at (916) 841-1130 for the listing of institutions selected to participate in this network and for coordination of referrals for evaluation. Members who are in a transplant treatment continuum must be cleared by the Blue Shield Medical Care Solutions Transplant Team for change of IPA. All requests should be sent to the Medical Care Solutions Transplant Department in Rancho Cordova.

Blue Shield Medicare Advantage Plan – Prior authorization for all Blue Shield Medicare Advantage plan evaluations and transplants is required and coverage subject to applicable Medicare coverage guidelines. These services must be performed at a Medicare-approved transplant facility for the specific transplant in question. The evaluation for Blue Shield Medicare Advantage members requires authorization by Blue Shield for members in a PPO product, and by the IPA/medical group for members in an HMO product.

Note: Charges incurred as a result of cadaver organ donor evaluation, donor maintenance, or organ recovery are directly reimbursable by the Organ Procurement Organization (OPO) according to federal law and therefore are not paid by Blue Shield. These charges may include but are not limited to extended hospital stay beyond the second death note, lab studies, ultrasound maintaining oxygenation and circulation to vital organs, and the recovery surgery. Blue Shield will pay the appropriate organ acquisition fee at the time the organ is transplanted. For Blue Shield Medicare Advantage plan transplants, Blue Shield will pay in accordance with contractual or Medicare fee schedules in accordance with Medicare coverage guidelines.

Commercial HMO and PPO – For HMO members, both the transplant evaluation and actual transplant procedure require prior authorization. The evaluation for HMO members requires authorization by the IPA/medical group or as otherwise specified. No self-referrals for transplant evaluations will be approved under the POS. For PPO members, with the exception of IFP PPO, the evaluation requires notification only. All Blue Shield members are entitled to transplant evaluations at any Blue Shield transplant network facility approved for the specified organ or transplant type, whether or not that facility has a contractual relationship with the IPA/medical group.

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Organ and Bone Marrow Transplants *(cont'd.)*

Transplant Authorization

When the evaluation is completed, the transplant coordinator at the transplant facility will send the transplant request to Blue Shield's Medical Care Solutions Team for medical necessity review and authorization.

Authorizations for transplants are required from Blue Shield Transplant Team for the following major organ and bone marrow transplant types:

- Bone marrow
- Stem cell
- CAR-T Therapy
- Cord blood
- Kidney and pancreas or kidney with another solid organ (for kidney only, see below)
- Heart
- Heart/lung
- Lung
- Liver
- Pancreas
- Small bowel with or without liver
- Multi-organ transplants (including kidney plus other organs)

The following transplants are also eligible for coverage but are handled as routine inpatient services by the designated Medical Care Solutions Prior Authorization Department for all members:

- Corneal
- Kidney only
- Skin

No special centers are required as long as a Blue Shield of California contracted facility is used, and, for kidney transplants, the facility is Medicare-certified.

Requests for transplants must include the following:

- Subscriber ID, requesting MD, applicable procedure and diagnosis codes
- Letter of request, including protocol reference
- Patient Selection/Bone Marrow Transplant (BMT) Committee Minutes/Tumor Board Recommendation
- Transplant Consult (from diagnosis to current/chemosensitivity/lab/staging)
- Synopsis of psycho-social and caregiver evaluation
- Comprehensive psychiatric evaluation (history of serious/prolonged mental illness)
- Documented completion of substance use disorder program (current history of substance use)
- Complete Transplant evaluation and workup

Fax the information to (916) 350-8865, Attn: Transplant Team

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Admission and Concurrent Inpatient Review

Blue Shield applies industry standard evidenced-based protocols and guidelines in the admission and concurrent review process. Blue Shield Medical Care Solutions reviewers may conduct concurrent review throughout an admission to determine level of care and continued medical necessity. The reviews may be conducted telephonically, electronically (electronic medical record access), reviewing faxed clinical records and/or with onsite reviews on an as needed basis.

Note: Authorization is not needed for a maternity admission for a routine delivery. If the baby stays after the mother is discharged, then the physician must contact Blue Shield for pre-certification of additional days for the baby.

Licensed clinicians evaluate for medical necessity and appropriateness of the level of care, including sub-acute care, and may require supporting medical documentation from the hospital including remote access to the hospital's electronic medical record. Hospitals must contact Blue Shield within 24 hours of admission. Authorization for additional days beyond the authorized length of stay must be obtained from the designated Medical Care Solutions team one day prior to the end of the authorized length of stay. Failure to request additional days prior to rendering services may result in non-coverage. The facility is notified within 72 hours of the request by telephone, fax, or in writing of the determination to continue the stay. If the provider is notified of the determination by phone, written notification will follow within 24 hours of the determination.

If the designated medical director or physician reviewer determines that the services are not medically necessary or at the appropriate level of care, he/she will contact the attending physician for a peer to peer discussion to develop a mutually agreed upon discharge plan.

A hospital employee, such as a Discharge Planner or Hospitalist, may request a referral for a member into one of Blue Shield's care management programs by contacting the Medical Care Solutions Reviewer.

To complete the authorization process and enable timely claims payment, the patient's discharge date and disposition must be communicated to Blue Shield Medical Care Solutions within 24 hours of discharge.

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Subacute Level of Care Criteria

Blue Shield will determine which subacute levels of care are applicable to the subacute services provided based on the following criteria:

Level I:

- (i) 24-Hour skilled nursing care observation and management;
- (ii) Routine oral, intra-muscular injection and subcutaneous drug administration;
- (iii) Intravenous administration (single);
- (iv) Insulin dependent (SQ Insulin);
- (v) Nasogastric tube, gastric tube, jejunostomy tube, or jejuno-gastric tube (enteral feeding services and supplies included);
- (vi) Colostomy/ileostomy care;
- (vii) Foley catheter care (with daily irrigations);
- (viii) Traction and Positioning;
- (ix) Up to two (2) hours of therapy per day, up to five (5) days per week of rehabilitation services for any combination of the following (evaluation included) by a licensed practitioner:
 - (A) Physical therapy.
 - (B) Occupational therapy, which includes Self Care, Dressing, Bathing, Toileting (B&B).
 - (C) Speech therapy, which includes swallowing/eating, Cognitive rehabilitation.
 - (D) Respiratory therapy.
- (ix) Wound care (Stage I, II) decubitus post-surgical wound/dressing care.

Level II:

All therapies as noted in Level I, plus the following additional care or conditions:

- (i) Intravenous administration and therapy (two or more medications); Central Lines, Total Parenteral Nutrition (TPN);
- (ii) Isolation;
- (iii) Tracheostomy care, Respiratory Care requiring frequent suctioning;
- (iv) Wound Care Stage 3 possible;
- (v) Two (2) to three (3) hours of therapy per day, up to five (5) days per week of rehabilitation services for any combination of the following (evaluation included) by a licensed practitioner:
 - (A) Physical therapy.
 - (B) Occupational therapy, which includes Self Care, Dressing, Bathing, Toileting (B&B).
 - (C) Speech therapy, which includes swallowing/eating, Cognitive rehabilitation.
 - (D) Respiratory therapy.

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Subacute Level of Care Criteria *(cont'd.)*

Level III:

All therapies as noted in Levels I and II, plus the following additional care or conditions:

- (i) Major wound care (Stage III or IV) Negative Pressure wound therapy pump (wound vac);
- (ii) Permanent tracheostomies (includes supplies);
- (iii) Chest tube(s);
- (iv) Shunt management;
- (v) Tracheostomy decanulation;
- (vi) Tracheostomy requiring enteral feeding;
- (vii) Peritoneal dialysis;
- (viii) Special beds (i.e. Hill-Rom, KCD);
- (ix) High-Cost medications IV/IM/SQ; IV TPN/Lipids.

Level IV:

All therapies as noted in Levels I, II and III, plus the following additional care or conditions:

- (i) Ventilator management; and/or
- (ii) Mutually agreed upon diagnoses requiring extensive skilled nursing care; 24-hour care.

Continuity of Care for Members by Non-Contracted Providers

Newly covered members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracted provider who was providing services to the member at the time the member's coverage became effective under their Blue Shield plan.

Existing Blue Shield members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracted provider who was providing services to the member at the time the provider's contract with Blue Shield terminated.

A member can request continuity of care services by completing Blue Shield's Request for Continuity of Care Services form, available by calling Blue Shield Member Services or downloading from blueshieldca.com, then either mailing or faxing the completed form for review to the address or fax number listed on the form at least thirty (30) days before the health plan takes effect or as soon as the member becomes aware of the need for continuity of care services.