Section 3: Medical Care Solutions

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Medical Care Solutions Program Overview

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 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 physicians, and 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 services and quality, and 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 members generally expected to benefit from Medical Care Solutions support include those with potential long-term, complex, or exceptional care needs, resulting from the following conditions:

- AIDS/HIV
- Cancer
- Chronic and disabling pulmonary diseases (e.g., asthma, emphysema)
- Cardiovascular disease
- Cerebral vascular accident
- Head/spinal cord injury
- Total joint replacement
- High-risk pregnancy
- Diabetes Mellitus
- Transplant (Solid Organ or Bone Marrow Transplant (BMT))
- End stage renal disease
- Members with complex conditions
- Members with coexisting medical and behavioral health conditions

Medical Care Solutions Program Overview *(cont'd.)*

In conjunction with Blue Shield Medical Care Solutions, the member, attending physician, and ancillary care providers participate in the member's plan of care. Blue Shield's Medical Care Solutions Department will contact the requesting provider(s) within 72 hours for urgent requests to inform them of the status of their request for care or services. The Blue Shield Medical Care Solutions staff will follow the Blue Shield Timeliness Standards for all other 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 nurses engage with members to ensure care needs are coordinated prior to, during, and after a hospital confinement.

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

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 *(cont'd.)*

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;
- 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.

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 Solutions 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.

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

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 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) guidelines. 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.

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 MPRP), 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).

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

Medication Policy *(cont'd.)*

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 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

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. Step therapy may also apply requiring the use of preferred agents including generic or biosimilar drugs. 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 does not match the authorization or 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 or Medication policy information is available through Provider Connection at blueshieldca.com/provider under *Authorizations, Clinical policies and guidelines* or by contacting Provider Information & Enrollment at (800) 258-3091.

For information concerning Blue Shield's member grievance process, refer to Section 1.

Practice Guidelines

Blue Shield is committed to improving health with optimal outcomes. Clinical practice and preventive health guidelines assist physicians by providing a summary of evidence-based recommendations for the evaluation and treatment of preventive aspects and select common acute and chronic conditions.

Blue Shield's Clinical Practice Guidelines focus on important aspects of care with recognized and measurable best practices for high-volume diagnoses. The basis of the Guidelines includes a variety of sources that are nationally recognized, or evidence-based, or are expert consensus documents. Additional points have been included where medical literature and expert opinion are noted. Network physician involvement is a crucial part of the guideline development, as well as adoption for the organization after approval by Blue Shield Committees.

Clinical Practice Guidelines are available on Provider Connection at blueshieldca.com/provider under *Guidelines & resources*, then *Guidelines and procedures*.

Use of Free-Standing Urgent Care Centers

Generally, Blue Shield urgent care physicians are not located in an acute hospital setting and are required to offer extended hours of operation, including weekends, and provide services to members without appointments.

Members should be referred to these physicians, rather than hospital emergency rooms, when appropriate and available for the level of service and care indicated. A list of currently contracted urgent care physicians may be found on blueshieldca.com/provider and in the Blue Shield provider directories.

Use of Out of Network Health Care Professionals and Facilities

Blue Shield members should be referred to in network health care professionals and facilities for services whenever possible to maximize the benefits available to them under their benefit plans and to provide those benefits at the lowest possible cost to the members. A provider type includes, but is not limited to, the provider types listed in Section 1 of this manual. Examples of other provider types include hospitals, ambulatory surgery centers, and DME vendors.

To assist members in making informed choices, Blue Shield requires providers to discuss the option of utilizing in network health care professionals and facilities when making a referral to an out of network health care professional or facility for non-emergent services. This policy is not intended to dissuade members from utilizing their out of network benefits, but instead is intended to help them understand the impact of their decisions. Often the use of an out of network health care professional or facility results in reduced benefits and/or higher out-of-pocket costs to the member.

If, after discussing the options available, the member chooses to receive services from an out of network health care professional or facility, the referring physician and the member must complete the *Member Advance Notice Form – Out of Network Referral* available on blueshieldca.com/provider in the *Guidelines & Resources* section, then *Forms* section, and then select the *Patient Care Forms* link. The original completed form must be filed in the member's medical record and be made available to Blue Shield within five (5) business days from the date of the request by Blue Shield.

Referral to Out of Network Health Care Professionals and Facilities

If Blue Shield confirms that it is not able to ensure reasonable access to care, providers will be able to request and obtain authorization for out-of-network services. Blue Shield will pay/price these services at the member's in-network benefit level.

Since members incur higher copayments and deductibles when out of network health care professionals or facilities are used, every effort must be made to ensure referrals are made to in network health care professionals and facilities. When there are no Blue Shield in network health care professionals (for specialty, acute care, ancillary care, etc.) or facilities available in the member's service area, the member or provider may request a referral to an out of network health care professional or facility. Providers requesting a referral to an out of network health care professional or facility must call Blue Shield at (800) 541-6652 or complete and fax the *Out of Network Referral Request Form* to (855) 895-3506. The *Out of Network Referral Request Form* is available on blueshieldca.com/provider in the *Guidelines & resources* section, then *Forms* section, and then select the *Patient care forms* link. Requests for referrals to out of network health care professionals and facilities must be made prior to services being rendered. Blue Shield will review the referral request. When a request is approved for an out-of-network referral, the member is covered at their in-network benefit level.

If, for some reason, a primary care physician, other health care professional specialty, acute care facility, or other provider is not available or accessible to a member whose benefit plan is affiliated with a narrow network, then Blue Shield will refer the member to the required professional or institution from its larger PPO Network to ensure member access to care. If, for some reason, the professional or institution is not available within Blue Shield's larger PPO Network, the *Out of Network Referral Request Form* must be generated for the member and the associated claim(s) is/are paid/priced at preferred in-network benefit levels. Examples of situations prompting a request for a referral to an out of network health care professional or facility include:

- There are no in network health care professionals accepting new patients.
- The in-network health care professional or facility are too far away for the member to see per approved access and availability standards.
- The member requires specific treatments that do not exist in-network.
- The in-network health care professional or facility are unable to perform a medically necessary service.
- The in-network health care professional is unable to admit the member to an in-network facility due to timing, capacity, etc.
- The in-network health care professional is unable to offer the member an appointment that meets regulatory timely access standards (e.g., within 10 business days of appointment request for non-urgent primary care, and within 15 business days of appointment request for non-urgent specialty care).

Billing Members for Durable Medical Equipment (DME)

Providers are not allowed to bill members for covered durable medical equipment (DME), and/or retrieve equipment that has been determined to be medically necessary by delegated entities. If, at any point during DME rental periods the member exhibits behavior that is not consistent with Blue Shield Medical Policy, the provider shall contact the delegated entity, inform them of the member's documented non-compliance with Blue Shield Medical Policy, and request their determination on continued use of the prescribed DME. Until a notice of non-coverage is received from the applicable delegated entity, the provider shall submit claims to Blue Shield for reimbursement. If the delegated entity issues a notice of non-coverage, the provider shall inform the member of their financial responsibility at that point, in writing, and/or retrieve the DME, as appropriate.

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.

Prior Authorizations

The term "prior authorization" means that approval for coverage requires prior submission of a request for non-urgent services (there is no prior authorization requirement for emergency services). Prior authorization is required for all non-emergent acute care hospitalizations and for certain procedures, drugs, place of care, or equipment. In addition, all non-emergent Blue Shield-managed behavioral health inpatient, residential, partial hospitalizations, intensive outpatient, and non-routine outpatient services require prior authorization.

For urgent or emergent admissions, Blue Shield must be notified by the attending physician or the hospital within 24 hours of admission. In addition, there are selected services and procedures which may be done in an ambulatory care setting or inpatient facility for non-emergent care that require mandatory prior authorization review for medical necessity, along with the prior authorization needed for an inpatient admission. Requests may be submitted to Blue Shield Medical Care Solutions via telephone, fax, or U.S. mail. In addition, providers have the option to complete, submit, attach documentation, track status, and receive determinations for medical and pharmacy prior authorizations via AuthAccel, Blue Shield's online authorization tool. Registered users may access the tool in the *Authorizations* section after logging into Provider Connection at blueshieldca.com/provider.

In most cases, providers may refer to in-network specialists without prior authorization. Medical necessity review by Blue Shield Medical Care Solutions may be required in certain geographic areas.

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

Prior Authorizations *(cont'd.)*

Prior Authorization Response Times

Medical Services

Non-urgent: Within five business days after receipt of request if all the necessary information is received at the time of the request.
Urgent: Within 72 hours after receipt of request if "urgent" criteria definition is met.

Medications

Non-urgent: Within 72 hours after receipt of request.
Urgent: Within 24 hours after receipt of request if "urgent" criteria definition is met.

"Urgent" is defined as an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision making might seriously jeopardize the life or health of the member. Scheduling issues do not meet the definition of "Urgent."

Certain self-funded employers have established agreements with independent review organizations other than Blue Shield. In such cases, the requesting provider should contact this review organization per the instructions on the member's identification card. Refer to the exhibit on the following page for a list of services requiring prior authorization.

Effective January 1, 2008, §1371.8 of the Health & Safety Code and §796.04 of the Insurance Code were amended to clarify that an authorization must be honored, and payment must be made even if the carrier later determines the enrollee is not eligible, regardless of the reason. Existing law has been expanded to apply only when:

- The plan has authorized a specific type of treatment.
- The provider rendered the service in good-faith reliance on the authorization.

Note: Within 5 days before the actual date of service, providers MUST confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Prior Authorizations *(cont'd.)*

Specialty Drug Prior Authorization for the Medical Benefit

Specialty drugs covered in the members' medical benefit may require prior authorization to establish medical necessity and appropriate place of care. "Place of Care" is defined as the options for physical location of administration. Places of care include the physician's office, outpatient hospital facility, ambulatory infusion center, or home health/home infusion. Certain specialty drugs covered in the members' medical benefit may require prior authorization to establish medical necessity, step therapy requirements, use of a biosimilar first, and approval to administer the drug at an outpatient hospital facility.

The Specialty Drug Prior Authorization requirements apply to all participating physicians, health care professionals, facilities, and ancillary providers ("Providers") that order or render certain specialty drugs.

> *Note: Failure to follow the Specialty Drug Prior Authorization process may result in administrative denial. Claims denied for failure to request prior authorization may not be billed to the member.*

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.

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 *Authorizations*, *Clinical policies and guidelines, Medication policy,* then *Medication policy list for Commercial and Medicare plans.*

The provider ordering the specialty drug is responsible for obtaining a prior authorization number prior to any rendering of the specialty drug, authorization for place of service if applicable and provide the rendering provider's contact information if different from ordering provider. A provider may request a prior authorization by contacting Blue Shield Medical Care Solutions at (800) 541-6652 or complete and fax the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) to (844) 262-5611. In addition, providers have the option to complete, submit, attach documentation, track status, and receive determinations for medical prior authorizations via AuthAccel, Blue Shield's online authorization tool. Registered users may access the tool in the *Authorizations* section after logging into Provider Connection at blueshieldca.com/provider.

A prior authorization number will be issued to the ordering provider when the prior authorization process is completed, and a determination has been reached.

Prior Authorizations *(cont'd.)*

Specialty Drug Prior Authorization for the Medical Benefit *(cont'd.)*

Medications

Non-urgent: Within 72 hours after receipt of request.
Urgent: Within 24 hours after receipt of request if "urgent" criteria definition is met.

"Urgent" is defined as an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision making might seriously jeopardize the life or health of the member. Scheduling issues do not meet the definition of "Urgent."

The determination will be communicated to the provider in writing and by phone/fax once the final determination has been made. If the rendering provider is different from the ordering provider, to help ensure proper payment, the prior authorization number should be obtained and communicated by the ordering provider to the rendering provider scheduled to render the specialty drug.

Please note that receipt of a coverage authorization means that the service met our criteria for medical necessity and/or met coverage and drug policy criteria, and place of care. It does not guarantee or authorize payment. If a place of care is not indicated by the ordering provider, Blue Shield of California will select a place of care for the member. Medication infusions at an outpatient hospital facility may require additional authorization for select specialty drugs. If the authorization for the place of care does not match the claim, the medication claim may be denied.

Payment of covered services is contingent upon the member being eligible for services on the date of service, the provider being eligible for payment, any claim processing requirements, and the provider participation agreement with Blue Shield of California. The length of time for which a prior authorization will be valid will vary by request.

Prior Authorization List for Network Providers

Contact Blue Shield Provider Customer Service Medical Care Solutions unless otherwise indicated at:

blueshieldca.com/provider
(800) 541-6652
Fax: (844) 807-8997

In addition, providers have the option to complete, submit, attach documentation, track status, and receive determinations for medical prior authorizations via AuthAccel, Blue Shield's online authorization tool. Registered users may access the tool in the *Authorizations* section after logging into Provider Connection at blueshieldca.com/provider.

ALL INPATIENT ADMISSIONS Require Prior Authorization

All electively scheduled admissions require prior authorization at least five business days prior to admission to the following facilities:

- Acute Inpatient
- Skilled Nursing
- Sub-Acute Care
- Hospice
- Mental Health
- Substance Use Disorder
- Acute Rehabilitation

Urgent / Emergent admissions require notification within 24 hours of admission.

OUTPATIENT PROCEDURES / EQUIPMENT

Prior Authorization/Pre-service Review Required

A complete list of procedures and their authorization requirements for coverage can be found on Provider Connection at blueshieldca.com/provider Under *Authorizations*, *Prior Authorization Forms and List.*

For Direct Contracting HMO: All outpatient surgical procedures performed in an acute hospital or free-standing Ambulatory Surgery Center setting require prior authorization.

Providers may submit prior authorization requests online at blueshieldca.com/provider under *Authorizations* then *Request a medical authorization.*

Prior Authorization List for Network Providers *(cont'd.)*

TYPE OF SERVICE / PROCEDURE	PPO AND DIRECT CONTRACT HMO
Ambulance Service Non-Emergency: Blue Shield covers non-emergency ambulance services using our contracted providers. Non-emergency ambulance requires prior authorization. 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. *Note: Non-Emergency services provided solely for the convenience of the patient or physician would not be covered.*	Go to Provider Connection at blueshieldca.com/provider and click on *Guidelines & resources, Patient care resources,* then *Ancillary provider rosters* to view a list of contracted ambulance providers or call Provider Information & Enrollment at (800) 258-3091 for information on contracted options.
All Homecare, Home Hospice, and Home IV	Prior authorization required (800) 541-6652 Fax: (844) 807-8997 or Submit online with attached documentation, track and receive determinations for medical authorizations via AuthAccel, at blueshieldca.com/provider in the *Authorizations* section.

Prior Authorization List for Network Providers *(cont'd.)*

TYPE OF SERVICE / PROCEDURE	PPO AND DIRECT CONTRACT HMO
Home-based Palliative Care Services Not Included in the Program Case Rate *Note: Patients newly enrolled in the program are eligible for expedited authorization of certain covered services (e.g., supplies, durable medical equipment (DME), oxygen, medications). Attach documentation that clearly states the member is in the Palliative Care Program and indicate that the request should be expedited. If you need additional help in this area, email* BSCPalliativeCare@blueshieldca.com.	Prior authorization required (800) 541-6652 Fax: (844) 807-8997 or Submit online with attached documentation, track and receive determinations for medical authorizations via AuthAccel, at blueshieldca.com/provider in the *Authorizations* section.
Laboratory Services Laboratory 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.	Prior authorization may be required (800) 541-6652 Fax: (844) 807-8997 or Submit online with attached documentation, track and receive determinations for medical authorizations via AuthAccel, at blueshieldca.com/provider in the *Authorizations* section.

Prior Authorization List for Network Providers *(cont'd.)*

TYPE OF SERVICE / PROCEDURE	PPO AND DIRECT CONTRACT HMO
Mental Health and Substance Use Disorder For commercial plans managed by Blue Shield's mental health service administrator (MHSA). This includes fully-insured HMO, PPO, EPO, and self-funded plans. Prior authorization is required for: • 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 plans *Evidence of Coverage* or *Health Service Agreement*. o Behavioral Health Treatment (BHT) including Applied Behavior Analysis (ABA). o Electro-convulsive Therapy (ECT) and associated anesthesia. o Intensive Outpatient Program. o Partial Hospitalization Program. o Neuropsychological Testing should be considered for coverage through the patient's mental health benefit when: ▪ 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). o Transcranial Magnetic Stimulation.	Contact MHSA (800) 378-1109
For Blue Shield Medicare Advantage Plans managed by Blue Shield's mental health service administrator (MHSA). Prior authorization is required for: • Inpatient admissions • Partial hospitalization programs • Intensive outpatient program • Office Based Opioid Treatment • Other Outpatient • Residential Treatment	Contact MHSA (800) 985-2398 Contact Blue Shield Medical Care Solutions (800) 541-6652 or Fax: (844) 807-8997 or online at blueshieldca.com/provider under *Authorizations, Authorization tools,* then *Request a medical authorization.*

Prior Authorization List for Network Providers *(cont'd.)*

TYPE OF SERVICE / PROCEDURE	PPO AND DIRECT CONTRACT HMO
FDA-Approved Prescription Pharmaceuticals / Drugs 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.)	A complete list of medications and their authorization requirements for coverage in the medical benefit, including place of care, can be found on Provider Connection at blueshieldca.com/provider under *Authorizations*, *Clinical policies & guidelines,* then *Medication policy.* Faxed requests must be submitted on the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) Providers may also submit prior authorization requests online at blueshieldca.com/provider under *Authorizations* then *Request a medical authorization.* An additional link to the *Medication Policies User Guide* is available on the *Medication Policy* homepage. Contact Blue Shield Medical Care Solutions (800) 541-6652 or Fax: (844) 262-5611 or Submit online, with attached documentation, via AuthAccel in the *Authorizations* section of Provider Connection at www.blueshieldca.com/provider.
Radiology The following radiologic procedures are managed by National Imaging Associates, Inc. (NIA): • CT, All examinations • MRI/MRA, All examinations • Nuclear Cardiology Imaging • PET (Positron Emission Tomography)	Prior authorization required Submit authorization requests online at RadMD.com or contact NIA at (888) 642-2583
Transplants Solid Organ and Bone Marrow Transplants	Prior authorization required Kidney / Cornea / Skin Transplants (800) 541-6652 SOT and BMT Transplants (800) 637-2066 ext. 841-1130 Fax: (916) 350-8865

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 but only 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 a California network transplant facility for benefits to be paid. Please 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 plan 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 is directly reimbursable by the Organ Procurement Organization (OPO) according to federal law and therefore is 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 – 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.

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 Transplant 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)

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

Transplant Authorization *(cont'd.)*

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. 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.

- Corneal
- Kidney only
- Skin

Requests for transplants must include the following:

- Subscriber ID, requesting MD, CPT/ICD-9/ICD-10-CM & ICD-10-PCS code(s)
- 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 disorder)
- Complete Transplant evaluation and workup

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

Drug Formulary

The Blue Shield of California Drug Formulary (formulary), maintained by the Blue Shield of California Pharmacy and Therapeutics (P&T) Committee, is designed to assist physicians in prescribing medically appropriate, cost-effective drug therapy.

The formulary contains medications approved by the Food & Drug Administration (FDA) which have been reviewed for safety, efficacy, bio-equivalency, and cost. The P&T Committee is the governing committee responsible for oversight and approval of policies and procedures pertaining to formulary management, drug utilization, pharmacy-related quality improvement, educational programs and utilization management programs, and other drug issues related to patient care. The Committee determines clinical drug preference for formulary inclusion, medication coverage policies and clinical coverage requirements based on the medical evidence for comparative safety, efficacy, and cost when safety and efficacy are similar. The voting members of the P&T Committee are practicing physicians and pharmacists in the Blue Shield network who are not employees of Blue Shield. The P&T Committee reviews drugs on a quarterly basis.

The formulary applies to members with outpatient prescription drug benefits through Blue Shield. Some drugs require prior authorization to determine medical necessity or to ensure safe use of a drug. Providers are encouraged to use the formulary to optimize drug benefits for our members, and to help them minimize their out-of-pocket expenses.

Blue Shield offers different types of outpatient prescription drug benefits. Drugs are placed into formulary drug tiers and member cost-share (copayment or coinsurance) for covered medications varies by tier.

For drugs that require prior authorization or an exception to benefit or coverage rules, coverage decisions are based on the medication coverage policies defined 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) 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 formulary drug alternatives.

Drug Formulary *(cont'd.)*

Commercial Plans

Pharmacy Benefit Medications. Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to complete and fax the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) to (888) 697-8122. This form is available on blueshieldca.com/provider under *Authorizations,* and then *Prior authorization forms and list*. Providers may also submit prior authorization requests online by going to blueshieldca.com/provider under *Authorizations* then *Request pharmacy authorization* or *Request pharmacy prior authorization electronically* to submit a prior authorization request through an ePA vendor.

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status, and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the Authorizations section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate California Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211), as the required information is built into the tool.

Medicare Plans

The Centers for Medicare & Medicaid Services (CMS) complies a "Preclusion List" of prescribers, individuals, and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. CMS will make the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by, or associated with, prescriptions written by prescribers and providers on the list. Full enforcement of the Part C and D prescriber exclusion list requirement began on January 1, 2019.

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to request a prior authorization or exception request by faxing a Medicare Coverage Determination Request Form (available at blueshieldca.com/provider) to (888) 697-8122 or via phone to (800) 535-9481 Monday through Friday, 8:00 a.m. until 6:00 p.m. PST, excluding holidays.

Drug Formulary *(cont'd.)*

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status, and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the *Authorizations* section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate Medicare Coverage Determination Request Form, as the required information is built into the tool.

Once all required supporting information is received, a coverage decision, based upon medical necessity, is provided within the following timelines:

Commercial plans within 24 hours for urgent requests and 72 hours for standard requests.

Medicare Part D plans within 24 hours for an expedited review and 72 hours for standard requests.

Specialty Drugs are covered at a copayment or coinsurance and most require prior authorization for coverage. Specialty Drugs are available through a Blue Shield Network Specialty Pharmacy.

The most current version of Blue Shield formularies and other information about Blue Shield prescription drug benefits and pharmacies can be accessed on blueshieldca.com in the *Provider Connection* or *Pharmacy* sections or by calling (800) 535-9481.

Note: Different drug formularies apply depending on the member's plan.

Mandatory Generic Drug Policy

In general, generic drugs should be prescribed whenever possible to help keep the member's out-of-pocket costs low. We recommend that physicians indicate or write *Generic Substitution Permitted/OK* on the prescription to inform the pharmacist to fill with a generic equivalent if available. 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. Most FDA-approved generic drugs are covered on the formulary. Transmitting a prescription using e-Prescribing technology provides the best method for determining and prescribing available generic equivalents and alternatives covered on the drug formulary.

If a brand name drug is dispensed when a generic is available upon request of the member or prescriber, the member may be responsible for paying the difference between the cost of the brand name drug and its generic equivalent, in addition to the associated drug copayment. Exceptions may be granted to cover the brand name drug at a plan copayment if medically necessary and use of the generic equivalent is not clinically appropriate for the individual patient.

Information about covered generic drugs on the formulary can be accessed on blueshieldca.com in the *Provider Connection* or *Pharmacy* sections.

Drug Formulary *(cont'd.)*

Mail Service Prescriptions

Members may have their prescriptions for medications taken on an ongoing, regular basis to maintain health filled by Blue Shield's mail service pharmacy and delivered to the location of their choice for convenience and to optimize their copayment. Prescriptions for mail service must be prescribed for a quantity to cover up to a 90-day supply. Prescriptions can be sent electronically, by phone, or by fax.

Information about contacting Blue Shield's mail service provider can be accessed on blueshieldca.com/provider in the *Guidelines & Resources* section.

Specialty Drugs

Specialty Drugs are drugs that may require special handling or manufacturing processes, coordination of care, close monitoring, or extensive patient training for safe self-administration that generally cannot be met by a retail pharmacy and are available at a Network Specialty Pharmacy. Specialty Drugs may also be drugs restricted by the FDA or drug manufacturer to prescribing by certain physicians or dispensing at certain pharmacies.

New prescriptions for Specialty Drugs should be sent to a Network Specialty Pharmacy who will provide no more than a 30-day supply of Specialty Drugs by mail or, upon a member's request, at an associated retail pharmacy for pickup, if available.

The list of Specialty Drugs and information about Network Specialty Pharmacies may be accessed at blueshieldca.com/pharmacy.

Specialty Drugs may be dispensed by any willing pharmacy for Medicare Part D plans.

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