601 12th Street
Oakland, CA 94607

October 17, 2025

Subject: Notification of January 2026 updates to the Blue Shield *Hospital and Facility Guidelines Manual*

Dear Provider:

Blue Shield is revising the *Hospital and Facility Guidelines Manual* (Manual). The changes in each provider manual section listed below are effective January 1, 2026.

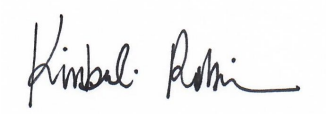
On that date, you can search and download the revised manual on Provider Connection at www.blueshieldca.com/provider in the *Provider Manuals* section under *Guidelines & resources*.

You may also request a PDF version of the revised *Hospital and Facility Guidelines Manual* be emailed to you once it is published by emailing providermanuals@blueshieldca.com.

The *Hospital and Facility Guidelines* is included by reference in the agreement between Blue Shield of California (Blue Shield) and the hospitals and other facilities contracted with Blue Shield. If a conflict arises between the *Hospital and Facility Guidelines* and the agreement held by the hospital or other facility and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the January 2026 version of this Manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,



Kimberli Robinson
Vice President, Network Operations

Beginning January 1, 2026, Blue Shield will administer all behavioral health services (mental health and substance use disorder services) that were previously administered by Magellan Health, Inc. ***Updates*** were made throughout this manual for behavioral health services administration. Additional information will be provided prior to January 1, 2026 via Blue Shield provider education and communications.

Section 1: Introduction

Member Grievance Process

Updated to delineate Commercial vs Medicare Advantage member grievance processes. ***Added*** language that the Potential Quality Issue (PQI) Referral Form can be found on Blue Shield's provider portal at www.blueshieldca.com/provider in the *Find forms* section at the bottom of the page, then *Reporting forms*.

Section 2: Hospital and Facility Responsibilities

Quality Management and improvement

Sensitive Health Information

Updated the term "transgender services" to "gender-affirming care" pursuant to AB 352.

Sensitive Services

Clarified that claims submitted for services related to rape and/or sexual assault are excluded from any cost sharing or patient liability pursuant to AB 2843.

Service Accessibility Standards for Commercial and Medicare

Deleted and ***replaced*** the following standards:

CATEGORY	STANDARD
Preventive Care Appointments	Within 10 business days
Regular and routine care PCP	Within 10 business days Within 30 calendar days (Medicare only)

Geographic Distribution

Added the following standard:

CATEGORY	STANDARD	COMPLIANCE STANDARD
Home Health Agency	Urban: 1 within 15 miles of each member Suburban 1 within 20 miles of each member Rural: I within 30 miles of each member	Urban: 90% Suburban: 85% Rural: 75%

Provider Availability Standards for Medicare Advantage Products

Deleted the Facility Time and Distance Requirements, Provider Time and Distance Requirements, and Provider Minimum Number Requirements tables and ***replaced*** with the following language:

Please navigate to www.cms.gov/medicare/health-drug-plans/medicare-advantage-application to view CMS requirements.

Language Assistance for Persons with Limited English Proficiency

Renamed section to **Cultural and Linguistic Program Overview** to align with program name and ***deleted*** and ***replaced*** entire section to improve clarity and conciseness.

Section 3: Medical Care Solutions

Changed section name to Medical Care Solutions/Behavioral Health Services.

Outpatient Authorizations

Updated/added authorization request information for the following services:

TYPE OF SERVICE / PROCEDURE	ALL LINES OF BUSINESS
Mental Health and substance use disorder	Effective January 1, 2026, authorization requests for mental health and substance use disorder treatment, including BHT/ABA, will be managed by Blue Shield. To request prior authorization, contact Blue Shield Behavioral Health Services at (800) 541-6652 or submit online by going to www.blueshieldca.com/provider under *Authorizations, Authorization tools,* then *Request a medical authorization.*
Oncology Drugs FDA-approved oncology drugs provided as part of a medical service and administered in the physician office, outpatient facility, or ambulatory infusion center are managed by Evolent. A complete list of medications and their authorization requirements for coverage in the medical benefit can be found on Provider Connection at www.blueshieldca.com/provider under Authorizations, Clinical policies & guidelines, then Medication policy.	Prior authorization required for Commercial and IFP PPO, group Medicare PPO, Administrative Services Only (ASO) and Shared Advantage PPO, HMO with Blue Shield directly contracted PCP, and Trio HMO with a virtual PCP. Submit oncology drug authorization requests online at **www.evolent.com/provider-portal**. Providers to select **CarePro** or contact Evolent at (888) 999-7713. Providers to select O**ption 2** for medical oncology
Oncology – Radiation Therapy The following radiation therapy procedures are managed by Evolent in the office/outpatient setting: • Brachytherapy • Conformal • IMRT • IGRT • Stereotactic Radiation • Proton and Neutron Beam Therapy	Prior authorization required for Commercial and IFP PPO, group Medicare PPO, Administrative Services Only (ASO) and Shared Advantage PPO, HMO with Blue Shield directly contracted PCP, and Trio HMO with a virtual PCP. Submit radiation therapy authorization requests online at **www.evolent.com/provider-portal**. Providers to select **CarePro** or contact Evolent at (888) 999-7713. Providers to select **Option 3** for radiation oncology
Radiology 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 Evolent. The following radiologic procedures are managed by Evolent: • CT, All Examinations • MRI/MRA, All Examinations • Nuclear Cardiology Imaging • PET (Positron Emission Tomography) 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.	Prior authorization is required for Commercial and IFP PPO, group Medicare PPO, certain Administrative Services Only (ASO) and Shared Advantage PPO, HMO with Blue Shield directly contracted PCP, and Trio HMO with a virtual PCP. Submit authorization requests online at **www.evolent.com/provider-portal**. **Providers to select RadMD** or contact Evolent at (888) 642-2583

TYPE OF SERVICE / PROCEDURE	ALL LINES OF BUSINESS
Spine surgery and pain management Spine surgery and pain management 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 Evolent. The following spine surgery and pain management procedures are managed by Evolent: • Lumbar and cervical spine surgeries • Epidurals, joint blocks, and joint injections Select spine surgery and pain management 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.	Prior authorization is required for Commercial and IFP PPO, group Medicare PPO, certain Administrative Services Only (ASO) and Shared Advantage PPO, HMO with Blue Shield directly contracted PCP, and Trio HMO with a virtual PCP. Submit authorization requests online at **www.evolent.com/provider-portal**. Providers to select **RadMD** or contact Evolent at (888) 642-2583

Section 4: Billing and Payment

Special Billing Situations

Genetic and Molecular Testing

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

Please refer to the Genetic and Molecular Testing Payment Policy on Provider Connection at www.blueshieldca.com/provider under *Claims, Policies and Guidelines,* then *Payment Policies and Rules.* Blue Shield Payment Policies are updated periodically to reflect the addition of newly released, revised, or deleted codes without notification.

Self-Referral

Updated the instructions for billing professional and institutional EDI claims.

Facility Compliance Review (FCR)

Added the following language describing the process for post-payment inpatient claim reviews, as follows:

For post-payment inpatient claim review/audits performed by Blue Shield, medical records or other supporting documentation is needed to complete the review/audit. A request shall be made to the facility indicating they have 60 calendar days from the date of the request to submit the requested information. The claims payment will be recouped for failure to submit the requested documentation for post-payment review/audit. In these instances, the member shall be held harmless for any such payment retractions based on the failure of the facility to submit the requested supporting documentation.

Provider Dispute Resolution

Unfair Payment Patterns

Updated the following bullet points describing unjust payment patterns, in strikethrough and boldface type pursuant to AB 3275:

- Failing to allow providers 30 ~~working~~ **calendar** days, at least 95% of the time over the course of any three-month period, of their right to dispute a request to recover an overpayment.

- Failing to process PPO and POS II, III clean claims within 30 ~~working~~ **calendar** days or HMO and POS I claims within ~~45 working~~ **30 calendar** days at least 95% of the time over the course of any three-month period.

Section 5: Blue Shield Benefit Plans and Programs

Medicare Part D

Medication Therapy Management Program (MTMP)

Added additional criteria that would allow a member to qualify for the MTMP, as follows:

2. Are determined to be an at-risk beneficiary (ARB), as defined by 42 CFR § 423.100, due to utilization of opioid and potentially benzodiazepine medications.

Blue Shield Medicare Advantage PPO Plans

Added the following language:

Beginning January 1, 2026, Blue Shield Medicare (PPO) is also an MA-PD Part B only plan. This plan is only open to members who are eligible for Original Medicare Part B. While this is the case, they will receive services covered under Original Medicare Parts A and D as well as supplemental benefits like vision, fitness, and others. Blue Shield Medicare (PPO) is offered to group Medicare beneficiaries retired from employer groups/unions who have selected the product as an option. Blue Shield Medicare (PPO) is not available to individual Medicare beneficiaries.

Expanded section to include details and contract numbers of each Medicare Advantage PPO plan that Blue Shield offers.

Federal Employee Program (FEP PPO)

Section heading has been ***changed*** to **Federal Employees Health Benefits (FEHB) Program and Postal Service Health Benefits Program (PSHB).** ***Added*** details of each program.

Care Management

Updated the email address for submitting Blue Shield Care Management program referrals to EDHCCMReferral@blueshieldca.com.

Wellness and Prevention Programs

Removed online nurse help as one of the programs within the NurseHelp 24/7 program.

Section 6: Capitated Hospital Requirements

Updated the term "misdirected claims" to "redirect claims" throughout section.

Incorrect Claims Submissions

Incorrect claims submissions, also known as ~~misdirected~~ **redirect** claims, are claims for capitated services that providers erroneously submit to Blue Shield for processing/payment instead of submitting appropriate claims or encounter reports to the capitated hospital.

Appendix 1-A Glossary

Updated definitions.

Appendix 4-A Reimbursement for Outpatient Services

Deleted and ***replaced*** Section VIII. Outpatient Pharmaceuticals to align the Blue Shield medical drug cost plus strategy with that of the pharmacy drug benefit cost plus strategy, as follows:

Blue Shield reimburses facilities for outpatient Pharmaceuticals using ASP-based Outpatient Pharmaceutical Fee Schedule, which is based on the Centers of Medicare & Medicaid (CMS) Average Sales Price (ASP). In the event that ASP pricing is not available, the facility reimbursement shall be at Wholesale Acquisition Cost (WAC). The WAC shall be derived from nationally recognized reference pricing sources selected by Blue Shield and shall be updated by Blue Shield quarterly.

If your agreement references Blue Shield AWP Outpatient Pharmaceutical Fee Schedule, it shall be based on the Average Wholesale Price (AWP). The AWP shall be derived from the same pricing sources as the WAC and shall be updated by Blue Shield quarterly.

For new drugs and drugs that are unclassified drugs, the facility must bill using the appropriate Revenue Code, unclassified CPT-4/HCPCS Code and NDC Code with description to receive payment.

To access your fee schedule, you can search and download the updated files on Provider Connection at www.blueshieldca.com/provider under *Claims, Facility and professional fee schedules, View facility fee schedules*, then *Pharmaceutical fee schedules*.

If you have questions about updates to the fee schedules, please contact your Blue Shield Provider Relations Coordinator.

Appendix 5-A The BlueCard® Program

Updated to align with the *BlueCross Blue Shield Association BlueCard Program Provider Manual*.

Appendix 6-C Claims, Compliance Program, IT System Security, and Oversight Monitoring

Renamed appendix to **Delegation Requirements for Claims and Oversight Monitoring** and ***removed*** Compliance Program and IT System Security Integrity language as it does not apply to this provider manual.

Key Terms and Definitions

Contested Claims – Commercial

Added the following language to comply with APL 25-007/AB 3275:

Beginning January 1, 2026, per All Plan Letter (APL) 25-007/Assembly Bill 3275 (AB 3275), commercial contested claims must be adjudicated within 30 calendar days after receipt of the claim and the Delegated Entity must notify the provider in writing that the claim is contested or denied. If a claim or portion thereof is contested on the basis that the Delegated Entity has not received information reasonably necessary to determine payer liability for the claim or portion thereof, reconsideration of the claim must be completed within 30 calendar days after receipt of the additional information. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by procedure or revenue code, and the specific reasons for the denial including any defect or impropriety.

Unaffiliated/Non-Contracted Provider – Commercial

Updated language to comply with APL 25-007, in strikethrough and boldface type as follows:

Commercial non-contracted provider claims must be adjudicated within ~~45~~ **30** working days of the date received to be considered compliant.

Measuring Timeliness and Accuracy

Interest Accuracy – Commercial

Added language below to comply with APL 25-007/AB 3275:

Beginning January 1, 2026 per APL 25-007/AB 3275, if a complete claim is not reimbursed within 30 calendar days after receipt, interest accrues at a rate of 15% per year beginning with the first calendar day after the 30-calendar-day period. Additionally, Delegated Entities must continue to automatically include all accrued interest when making payment on a claim beyond the 30-calendar day requirement.

Delegated Entities who fail to meet the above interest requirements shall also pay the claimant the greater of either an additional $15.00 or 10% of the accrued interest on the claim. Sections 1371(a)(4) and 1371.35(b), as effective 1/1/2026. The requirements for interest and penalty apply to all claims, including claims for emergency services and care.

Measuring Timeliness – Commercial Claims

Updated language in strikethrough and boldface type as follows:

Claim processing begins when a claim is first delivered to delegated payor's office. The number of days measured are ~~"working"~~ **"calendar"** days. The time limit to make payment ~~–45 working days~~ **30 calendar days**– applies to all claims, without regard to whether the billing providers are contracted or non-contracted. If a claim is to be contested the notice to that effect must be mailed within ~~45 working days~~ **30 calendar days.**

Commercial Provider Dispute Resolution (PDR)

Updated language below to comply with APL 25-007/AB 3275:

Beginning January 1, 2026, consistent with APL 25-007/AB 3275, interest and penalty, if applicable, are due on all claim payments that are not reimbursed within 30 calendar days after the date of receipt of a complete claim, including payments resulting from provider disputes.

Unclean or Contested Claims (Affiliated or Unaffiliated Providers) - Commercial (Contested)

Updated language below to comply with APL 25-007/AB 3275:

Beginning January 1, 2026, per APL 25-007/AB 3275, Delegated Entities must contest or deny a claim, or portion of a claim, as soon as practicable but no later than 30 calendar days after receipt of the claim. Delegated Entities must notify the claimant, in writing, that the claim is contested or denied.

The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by procedure or revenue code, and the specific information needed from the provider to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim. Delegated Entities may not contest a claim that is consistent with the procedure or revenue codes and services approved by prior authorization with appropriate documentation included on the claim.

If a claim or portion thereof is contested on the basis that the Delegated Entity has not received information reasonably necessary to determine payer liability for the claim or portion thereof, reconsideration of the claim must be completed within 30 calendar days after receipt of the additional information.

Best Practices and Claims Adjudication

Audits and Audit Preparation

Updated in boldface type and strikethrough, the following regarding the timeframe for written results of audit deficiencies:

Blue Shield will provide the Delegated Entity with written results within ~~10 business~~ **30 calendar** days including an itemization of any deficiencies and whether or not the Delegated Entity must prepare and submit a formal, written corrective action plan to include root cause and remediation within ~~10 business~~ **30 calendar** days of receipt of audit results. If supporting documentation/evidence is not provided the CAP will be closed as non-compliant.

Emergency Claims

Deleted and ***replaced*** the definition of Emergency Medical Condition to comply with AB 1316, as follows:

An "***Emergency Medical Condition***" is defined as a medical or mental health condition (and/or substance use disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- A mental health disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following, regardless of whether the patient is voluntary or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code):
  (A) An immediate danger to themselves or to others.
  (B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental health disorder.

Added the following new section:

Claims Oversight Monitoring

Delegated Entity shall implement controls to ensure claims processes are monitored for integrity and security to protect claims from being altered by unauthorized personnel.

- Delegated Entity shall not allow the same person or departments to have the ability to pay claims and enter or update providers, vendors and/or eligibility.
- Delegated Entity shall maintain a disaster recovery plan and provide it during the scheduled audit. The disaster recovery plan shall be reviewed and updated annually.