601 12th Street
Oakland, CA 94607

October 17, 2025

Subject: Notification of January 2026 updates to the Blue Shield *HMO IPA/Medical Group Procedures Manual*

Dear Provider:

Blue Shield is revising the *HMO IPA/Medical Group Procedures 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 *HMO IPA/Medical Group Procedures Manual* be emailed to you once it is published by emailing providermanuals@blueshieldca.com.

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

If you have any questions regarding this notice or about the revisions to 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

Section 2.5: Ancillary Benefits

Benefit Descriptions

Removed "and subsequent visits' from list of benefits from Acupuncture and Chiropractic services benefits.

Section 2.8: Benefits and Benefit Programs

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.

Pharmaceutical Benefits

Office Administered Medications

Added the following injectables to list of items included in California Health and Safety Code Section 1375.8 which stipulates a health care service provider is not required to assume or be at financial risk for any item described as a qualifying specialty pharmaceutical covered under the medical benefit:

- Qfitlia, Alhemo, and Hympavzi

Section 4.1: Network Administration

Provider Status Changes

Continuity of Care for Members by Non-Contracted Providers

Deleted specific timeframes for continuity of care and ***replaced*** with the following language to align with UM's P&P.

Continuity of Care timeframes are in accordance with applicable state or federal requirements, based on the member's group and coverage type.

Other IPA/Medical Group Responsibilities

Practice Locations and Patient Acceptance Restriction

Changed limits on PCP in-person practice locations from 7 to 6 and specialty practice locations from 11 to 10.

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.

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.

Section 4.2: Member Rights and Responsibilities

Member Grievance Process

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 4.4: Claims Administration

Claims Processing

Claims for Medical Benefit Drugs

Noted that Blue Shield assumes the financial responsibility for childhood immunizations unless the IPA/medical group opts to take on the financial risk of all office administered drugs.

Added the following language about injectable medications:

Providers are expected to acquire and administer injectable drugs as closely to the prescribed target dose as possible using one or more available vials. Units in excess of unavoidable or reasonable drug waste may be denied.

Claims for Outpatient Prescription Drugs

Clarified that medications administered at home, subcutaneously or intramuscularly, are covered in the member's Outpatient Prescription Drug Benefit and **cannot be submitted under the medical benefit.**

Incorrect Claims Submissions

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

Section 4.5: Provider Dispute Resolution

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 5.1: Utilization Management

Medical Benefit Drugs

Updated language in strikethrough and boldface type below:

IPA/ medical groups ~~may~~ **will** be subject to audit of medication coverage determinations according to Blue Shield medication policies by their Delegation Oversight Nurse in consultation with a Blue Shield pharmacist.

Mental Health and Substance Use Disorder Services

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 section related to prior authorization, utilization management, and contact information for behavioral health services administration. Additional information will be provided prior to January 1, 2026 via Blue Shield provider education and communications.

Blue Shield Mental Health Covered Services and Financial Responsibility

Updated language to indicate that Blue Shield provides authorization for Commercial, limited Group MAPD, and Individual MAPD members.

IPA/Medical Group Covered Services and Financial Responsibility

Deleted and ***replaced*** the following bullet point to align with SB 855 requirements.

- Decisions related to delegated medical services. As such, medical services for gender affirming care, eating disorder, or substance use disorder are the responsibility of the IPA/medical group. In making utilization management decisions, the IPA/medical group will utilize ASAM (substance use disorder), LOCUS (mental health ages 18 and older), CALOCUS (mental health ages 6-17), and WPATH (gender affirming care) guidelines. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.

Prior Authorization

Added subcutaneous Hemophilia therapies Qfitlia, Alhemo, and Hympavzi to list of injectable therapies that may require prior authorization.

Updated the following bullet points regarding prior authorization services that are NOT delegated to the IPA/medical group:

- To obtain a service authorization, the IPA/medical group should call the Blue Shield Behavioral Health Solutions Department at (800) 541-6652. Requests for service authorization should be made at least five business days in advance of service provision. Blue Shield will issue a determination. Services without an authorization that require an authorization will be denied.
- Effective January 1, 2026, requests for MH/SUD services should be made directly through Blue Shield.
- In addition to contacting Blue Shield by telephone or fax for medical authorizations, providers have the option to complete, submit, attach documentation, track status, and receive determinations for prior authorizations through the Availity Essentials portal. Registered Availity users may access Availity directly at www.availity.com/authorizations/. Availity may only be used for services where the division of financial responsibility in the IPA/medical group's contract identifies Blue Shield as responsible for prior authorization.

Section 5.2: Quality Management Programs

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.

Section 6.1 Blue Shield Medicare Advantage Plan Program Overview

Individual Blue Shield Medicare Advantage Plan HMO Dual Eligible Special Needs Plan (D-SNP) Service Areas

Deleted and replaced service areas with the following:

- Los Angeles County
- San Diego County

Section 6.2 Blue Shield Medicare Advantage Plan Benefits and Exclusions

Updated the Blue Shield Medicare Advantage Customer Care Services phone number to (800) 541-6652.

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.

Section 6.6 Blue Shield Medicare Advantage Plan Member Rights and Responsibilities

Member Rights and Responsibilities

Updated the contact information for the Blue Shield Civil Rights Coordinator to:

Blue Shield of California Civil Rights Coordinator
P.O. Box 927
Woodland Hills, CA 91367
Phone: (800) 874-5487 (TTY: 711) Fax: (916) 350-6510
Email: Appeal&GrievanceResol@blueshieldca.com

Member Grievance Procedures

Minor ***updates*** to remove language that is not relevant to the Blue Shield Medicare Advantage grievance process.

Appendix 1-A Glossary

Updated definitions.

Appendix 4-A: Claims, Compliance Program, IT System Security, and Oversight Monitoring

Renamed appendix to **Delegation Requirements for Claims and Oversight Monitoring** and *moved* Compliance Program and IT System Security Integrity language to Appendix 4-E.

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 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/Specialty Health Plan 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/Specialty Health Plans 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 Entity/Specialty Health Plans 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/Specialty Health Plan 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/Specialty Health Plan with written results within ~~10 business~~ **30 calendar**, from the scheduled audit date, including an itemization of any deficiencies and whether or not the Delegated Entity/Specialty Health Plan 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 nonprofit associations to list of treatment criteria used for level of care determinations pursuant to APL 24-007.

- Applied Behavior Analysis (ABA) Therapy- Council on Autism Providers (CASP) as documented in our Blue Shield Medical Policy.
- Neuropsychological Testing-American Psychological Association as documented in our Blue Shield Medical Policy.
- Transcranial Magnetic Stimulation (TMS)-Canadian Network for Mood and Anxiety Treatments (CANMAT) as documented in our Blue Shield Medical Policy
- Electroconvulsive Therapy (ECT)-American Psychiatric Association as documented in our Blue Shield Medical Policy

Added the following new section:

Claims Oversight Monitoring

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

- Delegated Entity/Specialty Health Plan 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/Specialty Health Plan shall maintain a disaster recovery plan and provide it during the scheduled audit. The disaster recovery plan shall be reviewed and updated annually.

Appendix 4-C 2026 Actuarial Cost Model

Added cost model examples for 2026.

Appendix 4-E Delegation Requirements for Compliance Program and IT System Security Integrity

Removed Compliance and IT Systems Security Integrity language from Appendix 4-A and created Appendix 4-E therefrom. Appendix 4-E details the process for conducting compliance oversight and monitoring of our contracted Delegated Entities, Specialty Health Plans, third-party MSOs, and IPA/medical groups (collectively, "Entities").

Appendix 5-B: Credentialing/Recredentialing Standards

VIII. Sub-Delegated Credentialing/Recredentialing Activities

Updated the standards to indicate that the delegation agreement should include a review of annual training.