



October 16, 2026

Subject: Notification of January 2027 updates to the *Blue Shield of California Independent Physician and Provider Manual*

Dear Provider:

Blue Shield of California (Blue Shield) is revising the *Independent Physician and Provider Manual* ("Manual"). The changes in each *Manual* section listed below are effective January 1, 2027.

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

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

The *Independent Physician and Provider Manual* is included by reference in the agreement between Blue Shield of California and those physicians and other healthcare professionals who are contracted with Blue Shield. If a conflict arises between the *Independent Physician and Provider Manual* and the agreement held by the individual and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions to be published in the January 2027 version of this *Manual*, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091, between 6 a.m. and 6:30 p.m. PT, Monday through Friday.

Sincerely,

A handwritten signature in black ink that reads "Kimberli Robinson".

Kimberli Robinson
Vice President, Network Operations

blueshieldca.com

Section 1: Introduction

Enrollment and Eligibility - Provider Requests to Transfer or Disenroll Blue Shield Medicare Advantage Plan Members

Updated the section name and references throughout the section to remove "or disenroll." This section only pertains to transferring a member to a different provider, not disenrolling a member from Blue Shield.

Member Grievance Process

Reporting PQIs

Deleted and replaced the following language to comply with an National Committee for Quality Assurance (NCQA) requirement:

To report potential or suspected deviations from the standard of care, submit a Potential Quality Issue (PQI) Referral Form to Blue Shield. A clinical quality reviewer will investigate and compile a case summary from clinical documentation including, but not limited to, medical records and a provider written response, if available. The case is then forwarded to the Clinical Quality Medical Director for review and determination of potential quality-of-care issue, adverse event, or sentinel/never event. A case review may also include a review of the care provided by a like-peer specialist and/or review by the Blue Shield Peer Review Committee.

Following review completion, quality findings may result in an education letter or a corrective action plan (CAP), depending on severity. If an education letter or CAP is issued because of a quality of care finding, the provider is expected to take appropriate actions to remediate the quality-of-care issue in accordance with the requirements set forth in education and/or the accepted CAP. Blue Shield will follow up with the provider to monitor the implementation of the corrective action to ensure that the appropriate actions have been taken to address the quality-of-care issue. Patient safety concerns or patterns of poor care may be considered during Blue Shield recredentialing activities or reviewed in more detail by the Blue Shield Credentialing Committee and may result in termination from the Blue Shield network.

To access the PQI Referral Form, visit Blue Shield's Provider Connection website at www.blueshieldca.com/provider, click on *Guidelines and resources* at the top of the page, select *Patient Care Resources*, then *Provider and patient care programs*. Click *View our programs*, navigate to "Quality and patient safety," and click *Blue Shield Potential Quality Issue Reporting Form*.

Section 2: Hospital and Facility Responsibilities

Credentialing and Recredentialing - Credentialing Application and Supporting Documentation

Updated section in boldface type:

Practitioners are required to submit a completed **NCQA**-approved application appropriate to their specialty (e.g., the **Council for Affordable Quality Healthcare, (CAQH)** or the California Participating Practitioner Application (CPPA)), with the following supporting documentation:

Specialty Credentialing Specifications

Added the following new section to comply with California Assembly Bill 1041 (AB 1041):

Healthcare Provider Credentials

Assembly Bill 1041 (AB 1041) requires the following procedures be put in place for healthcare providers, effective January 1, 2027:

- For healthcare providers, with the exception of mental health/substance use disorder specialists requesting credentialing:
 - Blue Shield utilizes the Council for Affordable Quality Healthcare (CAQH) provider portal as its primary source for credentialing applications. For applications submitted through CAQH, the application receipt date is established on the date the completed CAQH file is received and made available to Blue Shield for review.
 - Blue Shield shall notify the applicant within ten (10) business days to verify receipt and inform the applicant whether the CAQH application is sufficient for processing or if additional information is needed.

A determination shall be made regarding the credentials of a provider within 90 days after receiving a credentialing application that is sufficient for processing, including all required third-party verifications. The 90-day timeline shall apply only to the credentialing process and does not include contracting completion.
 - Provisional Approval: If the 90-day requirement is not met, the applicant's credentials will be provisionally approved for 120 days, unless any of the following apply:
 - The applicant is subject to discipline by the licensing entity for that applicant.
 - The applicant has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank.
 - The applicant has not been credentialed by Blue Shield in the past five years.
 - The provider shall be notified of the credentialing decision within ten (10) calendar days of clean file approval.

To prevent processing delays, providers should register and maintain a current and active CAQH ProView profile.

Delegation of Credentialing

Added this new section to ensure delegated entities/specialty health plans that contract under the professional and provider agreements have access to the delegation of credentialing standards.

Medical Record Review

Deleted language in strikethrough: Upon request, additional copies must be provided to Blue Shield. ~~at the provider's reasonable and customary copying costs, as defined by California Health and Safety Code 123110.~~

Quality Management and Improvement

Added a new section "Healthcare Provider Responsibilities for Coordination of Care" that details how contracted providers are expected to work collaboratively with Blue Shield by:

- sharing information effectively
- managing care transitions
- addressing medical, behavioral, and social needs
- engaging members and caregivers in their care, and
- complying with quality and regulatory requirements to ensure coordinated, whole-person care.

Service Accessibility Standards

Deleted and replaced grids in the following sections to comply with NCQA standards.

- Service Accessibility Standards for Commercial and Medicare
- Geographic Distribution
- Behavioral Health Geographic Access Standards
- Provider-to-Member Ratio

CMS Network Adequacy Requirements for Medicare Advantage Products

Added the following sub-section:

Medicare GeoAccess and Provider-to-Member Ratios (Behavioral Health and Non-Behavioral Health)

The availability of providers, as established by CMS, is measured by the number of required providers, travel distance, and travel time to providers. Blue Shield demonstrates that 90% of its provider network meets CMS time and distance standards and complies with the minimum number of providers for each CMS-designated specialty.

CMS Health Services Delivery (HSD) Reference File tables, available at www.cms.gov/medicare/health-drug-plans/medicare-advantage-application under *Downloads*, list the commonly reported provider and facility specialty types required by CMS. These specialty types are subject to annual CMS updates.

Cultural and Linguistic Program Overview

Reorganized the section and **added** the following contact information:

- **Requesting Services:**
 - **Interpreter Services for Scheduled or On-Demand Needs:**
 - To request interpreter services for Blue Shield patients enrolled in a CalPERS plan, please call (833) 220-8014 and provide Client ID# 34091.
 - For all other Blue Shield patients, please call (833) 220-8015 and provide Client ID# 34094.
 - **For translation requests**, email the request form (see forms under the Health Equity Resources and Training section) to BSCProviders@biglanguage.com.
 - **For any additional support**, contact Blue Shield Provider Services at (800) 541-6652 between 6 a.m. and 6:30 p.m. PT, Monday through Friday.

Section 3: Medical Care Solutions

Prior Authorization

Added language in bold: In most cases, providers may refer to in-network specialists **for consultation or evaluation** without prior authorization.

Prior Authorization List for Network Providers

Updated the Oncology Drugs line item with information about when inpatient administration is required and the Radiology line item on where to find prior authorization information online.

Electronic Claims Processing

Deleted and replaced with the following language about clearinghouse fees: Providers are responsible for any fees charged by clearinghouses for electronic claim submissions.

Special Billing Situations

Added the following new section:

Maternity Billing

In alignment with the American Medical Association (AMA) CPT maternity care coding restructure, effective January 1, 2027, Blue Shield requires maternity services to be billed in accordance with current AMA CPT coding guidelines. Maternity care services must be reported using a phase-of-care methodology rather than a global obstetrical package.

Key requirements include:

Procedure Coding

- **Antepartum (Prenatal) Care** – Report prenatal services using the appropriate Evaluation and Management (E/M) code(s) based on the service rendered and documentation supporting the visit.
- **Labor Management** – Report labor management services using the applicable CPT code(s) in accordance with AMA CPT guidelines.
- **Delivery Care** – Report delivery services separately using the appropriate CPT delivery code. Only the provider who performs the delivery may bill for delivery services.
- **Postpartum Care** – Report postpartum services using the appropriate E/M code(s) based on the services rendered and documented.

Primary Diagnosis

- Maternity services must be billed with appropriate maternity-related diagnosis code(s) that accurately reflects the member's condition and supports the services rendered.

Modifier TH

- Blue Shield recommends appending Modifier TH to eligible claims to identify services related to obstetrical treatment, prenatal care, or postpartum care, consistent with applicable AMA CPT®, HCPCS, and Blue Shield billing requirements.

Providers must submit claims that accurately reflect the services furnished and maintain documentation that supports the reported service(s). When multiple providers participate in a member's maternity care, each provider must bill only for the services they personally rendered.

Blue Shield may apply claims editing and reimbursement methodologies consistent with AMA CPT guidelines, industry standard coding practices, applicable regulatory requirements, and Blue Shield payment policies. Claims submitted with obsolete global maternity package codes for dates of service on or after January 1, 2027, may be denied or processed in accordance with Blue Shield reimbursement policies.

Special Billing Situations - Office Administered Injectable Medications

Noted that for Commercial PPO Plans, select medications are available for Drop Ship from a Blue Shield preferred program in network specialty pharmacy.

Deleted language: "Drop Ship requests are triaged by our Blue Shield vendor" as we no longer engage with a vendor for this program.

Overpayments

Added the following language:

The address for submitting refunds to Blue Shield for overpayment will change, effective January 1, 2027.

- Address through December 31, 2026: Blue Shield of California, P.O. Box 241012, Lodi, CA 94241
- Address effective on and after January 1, 2027: Blue Shield of California, P.O. Box 60512, City of Industry, CA 91716-0512

Provider Dispute Resolution - Unfair Billing and Payment Patterns

Under the sub-heading "How to submit a Provider Dispute" **added** language to clarify that this process applies to the mandatory first level of appeal.

Under the sub-heading "Final Provider Disputes," **added** language in boldface type as follows:

Unless the provider agreement requires two levels of appeals, the provider or capitated entities that disagree with Blue Shield's written determination may pursue the matter further by initiating a final **provider** dispute.

Section 5: Blue Shield Benefit Plans and Programs

Blue Shield Medicare Advantage Plans

Updated list of Medicare Advantage plans offered by Blue Shield to include plans that utilize a High Performing Network (HPN) which is a new tailored and exclusive network.

Blue Shield Medicare PPO Plans

Updated the list of Medicare Advantage PPO plans offered by Blue Shield.

Blue Shield Medicare PPO Service Area

Deleted and replaced with the following: Blue Shield Medicare plans are available exclusively to individuals who reside within the plan's designated service area. To maintain eligibility and remain enrolled in the plan, members must continue to reside within this service area. The service area includes all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Blue Shield Medicare Supplement Plans

Updated the list of Medicare Supplement plans and group numbers.

Mental Health and Substance Use Disorder Services

Added language in boldface type as follows: **Commercial** Blue Shield members may **self-refer** to **all** behavioral health services by calling the Customer Service number on the back of their card.

Care Management

Deleted the following language:

The care team prepares members in advance for hospital stays, including guided imagery recordings, to assist members in preparing for surgery or dealing with other health issues.

Deleted the following from list of services offered through the care management programs:

- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- Cognitive behavioral therapy modules

Added the following new section and a corresponding flow chart to comply with a 2026 NCQA PHM 3B requirement:

Provider Coordination

The PCP or IPA/medical group is responsible for coordinating basic care management services to meet the specific needs of each member and for implementing the care management plan under the oversight of Blue Shield. Blue Shield oversees the coordination of care among providers, tracks member progress, updates care plans as needed, and facilitates communication with other providers to promote continuity of care. The PCP or IPA/medical group must maintain thorough documentation that captures the delivery of care, progress toward member goals, and the interventions used to address identified care needs.

Additional Care Management Program Descriptions

Deleted the Home-Based Complex Care program from the list of Care Management programs as this program is no longer offered to members.

Appendix 2-A. Blue Shield Bylaws

Added latest version of Bylaws which are effective 6/1/26.

Appendix 2-C. Credentialing/Recredentialing Delegation Standards

Added this new appendix to ensure delegated entities/specialty health plans that contract under the professional and provider agreements have access to the delegation of credentialing standards.

Appendix 4-C CMS 1500 General Instructions

Updated instructions for Block 17, as follows:

Line 17, added: For ancillary claims (e, g., clinical labs, DME, and specialty pharmacy), the referring/ordering physician name is required.

Line 17b, added: For ancillary claims (e, g., clinical labs, DME, and specialty pharmacy), the referring/ordering physician National Provider Identifier is required.

Updated instructions for Block 24d to include: For Telehealth HIPAA compliant video services, enter place of service 02 Telehealth Provided Other Than in Patient's Home or 10 – Telehealth Provided in Patient's Home in 24b.

Appendix 5-A The BlueCard® Program

Added a new section on Medicaid Claims to comply with a Blue Cross Blue Shield Association provider education mandate.

Appendix 6-A Blue Shield Medicare Advantage Required Billing Elements

Updated the vendors used for CMS expedited reviews to: Commence Health or Acentra Health, depending upon the service area.