



601 12th Street
Oakland, CA 94607

April 22, 2026

«Provider»
«Title»
«Address1» «Address2»
«City», «State» «Zip»

Subject: Notification of July 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 July 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 Manual* 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 Manual* 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 July 2026 version of this Manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

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

Kimberli Robinson
Vice President, Network Operations

blueshieldca.com

Updates to the July 2026
Hospital and Facility Guidelines Manual

Section 1: Introduction

Member Rights and Responsibilities

Deleted and *replaced* commercial rights and responsibilities to comply with AB 118 – Compliance with Standardized Evidence of Coverage/Disclosure Form.

Fraud Prevention - Provider Audits

Updated the following language: The provider shall permit the inspection, audit, and duplication of records, including downloading to a secure drive when necessary. All member records required to complete an audit, or inspection shall be provided upon request.

Section 2: Hospital and Facility Responsibilities

Accreditation

Updated Blue Shield's accreditation status.

Service Accessibility Standards for Commercial and Medicare

Clarified that regular and routine care PCP is within 30 business day of request for Medicare (previously stated within 30 calendar days).

Provider Availability Standards for Commercial Products - Geographic Distribution

Added "or 60 minutes" to High-Volume and High-Impact Specialists standards: One High-Volume Specialists of each type and one High-Impact Specialists of each type within 30 miles or **60 minutes** of each member.

Provider Availability Standards for Commercial Products - Provider-to-Member Ratio

Changed compliance target for PCPs from 100% to 80%.

Cultural and Linguistic Program Overview

Added Arabic to Covered Ca/HMO threshold languages.

Removed Medicare plan type H2819-002, 003 and Medicare plan type H4937-001,002 from the Blue Shield Threshold Languages chart.

Added language for clarity: Blue Shield does not delegate language assistance services unless specifically stated in a delegation agreement. Providers may be authorized to issue certain utilization management and claims documents under relevant regulations.

Section 3: Medical Care Solutions

Medical Necessity

Updated in boldface type below to align with SB 855 CDI regs:

Medically necessary treatment of a MH/SUD 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: Not primarily for the economic benefit of the health care service plan/**disability insurer** and subscribers/**insureds** or for the convenience of the patient, treating physician, or other health care provider.

Section 3: Medical Care Solutions

Utilization Management Criteria and Guidelines

Updated section to align with SB 855 CDI regs.

Added the following new section:

Utilization Management Adverse Determinations / Denials

Peer-to-Peer (P2P) Clinical Discussion

Following adverse utilization review determinations, which includes denials, delays, or modifications of requests for authorization, the member's requesting, treating, or attending provider has the opportunity to request and engage in a peer-to-peer (P2P) clinical discussion with a Blue Shield Medical Director, or designated peer reviewer acting on behalf of Blue Shield, who was responsible for, or authorized to render, the adverse determination.

P2P discussions are intended to provide clarification of the clinical rationale for the adverse determination, and to allow for clinical dialogue regarding medical necessity. These discussions do not constitute an appeal, do not replace formal appeal rights, and do not delay or extend applicable appeal timeframes.

Instructions for requesting a P2P discussion, including applicable contact information, are included in the adverse determination notification. Participation is limited to the member's requesting, treating, or attending provider and does not include office staff, non-treating providers, or third-party representatives of the member or requesting, treating, or attending provider.

Outpatient Authorization Chart

Added language:

Note: Products regulated by the California Department of Insurance (CDI) do not require prior authorization for services other than "Non-emergency MH/SUD Hospital admissions, including acute and residential care" to MH/SUD section in chart per 2022 CDI directive related to product filing.

Updated Oncology Drugs, Oncology - Radiology Therapy, Radiology, and Spine surgery and pain management line items with more detailed information about where to find prior authorization information online.

Section 4: Billing and Payment

Claims Submission

Removed the section **Real Time Claims Settlement** as this tool has been retired and will no longer be available on our Provider Connection website, effective March 25, 2026.

Claims Processing Logic and Payment Policies - Prepayment Claim Review

Added the following new section:

Prepayment Claim Review

Blue Shield providers are expected to follow accepted ethical billing practices. Blue Shield is committed to high quality, cost-effective care and monitors the coding and billing patterns of health care providers. Our monitoring program is designed to detect billing irregularities, including "unbundling" of services and procedure coding inconsistent with current standardized guidelines. Blue Shield strives to make its claim payment policies transparent to providers. Blue Shield has implemented claims editing software systems based on industry standards, in order to pay providers fairly, accurately, consistently and in a standardized manner. Our claims editing software systems provide additional levels of automated claims adjudication.

Special Billing Situations - Hospice Billing (GMAPD Medicare Advantage Part B Only)

Added the following new section:

Hospice Billing (GMAPD Medicare Advantage Part B Only)

Normally, hospice is carved out to Original Medicare for Medicare Advantage members. For GMAPD Medicare Advantage Part B Only members, Blue Shield assumes full risk and pays for all hospice care, because CMS does not cover hospice for those without Part A eligibility. All hospice services related to the terminal prognosis are covered by Blue Shield, not CMS. Hospice providers must bill Blue Shield directly, not Medicare.

Hospice care must be provided by a Medicare-certified hospice provider within Blue Shield's network (or via Global Core for U.S. territories).

Special Billing Situations - Self Referral

Updated billing instructions for submitting Professional 837P claims and Institutional 837I EDI claims.

Provider Dispute Resolution - Unfair Payment Patterns - Levels

Added and *removed* language in boldface type and strikethrough as follows:

CCR, Title 28, Section 1300.71.38 requires health plans to offer a provider dispute resolution process. State law **and the arbitration process** do not require ~~health plans to offer a provider to complete~~ two levels of dispute.

Provider Dispute Resolution - Unfair Billing and Payment Patterns - Arbitration

Removed "and final" from the following: If after participating in the initial ~~and final~~ levels of the Dispute Resolution Process.

Provider Disputes of Medicare Advantage Claims - Non-Contracted Providers

Per APL 25-17 Introduction of additional IMR Organization, *removed* references to Maximus Federal Services (the CMS-contracted IMR vendor) and *added* language: The provider may request an independent medical review, conducted by a CMS-contracted organization, to evaluate the dismissal decision within 60 calendar days.

Section 5: Blue Shield Benefit Plans and Programs

Federal Employees Health Benefits Program and Postal Service Health Benefits Program PPO

Added language in boldface type to description of types services that must be approved in advance, as follows:

Laboratory and pathology services, X-rays and diagnostic tests billed by non-preferred laboratories, radiologists, and outpatient facilities. **Prior authorization is required for scheduled testing.**

Added contact number for services received outside of the United States, Puerto Rico, and the U.S. Virgin Islands: (888) 999-9862.

FEHB and PSHB - Mental Health and Substance Use Disorder Services for FEP

Added language: Residential Treatment Center admissions require prior authorization.

Added contact number for Telehealth: (855) 636-1579.

FEHB and PSHB - Required Prior Authorization Chart

Added the following line items to the Prior Authorizations Chart: Cochlear implants and residential treatment centers. **Removed** gender affirmation surgery. **Updated** outpatient facility-based sleep studies, rehab services, and surgical services.

FEHB and PSHB - Integrated Care Management Program

Removed the Palliative Care program from the list of programs offered by Integrated Care Management.

Wellness and Prevention Programs - LifeReferrals 24/7SM

Added a registration option for the LifeReferrals program at www.lifereferrals.com.

Wellness and Prevention Programs - Preventive Health Guidelines

Added the California Department of Public Health as one of the Preventive Health Guideline sources per APL 25-015: AB 144.

Appendix 1-A Glossary

Per APL 25-17, **updated** the definition of External Independent Medical Review to include the new CMS IMR organization, Managed Medical Review Organization, Inc.

Appendix 4-D List of Incidental Procedures

Deleted codes 0042T, C5272, C5274, C5276, C5278, Q4100, Q4106 and Q4116.

Appendix 4-E List of Office-Based Ambulatory Procedures

Deleted codes 0272T and 0273T.

Appendix 4-F UB-04 General Instructions

Added claim examples to the instructions.

Appendix 5-A The BlueCard® Program

Updated product names to comply with BCBSA brand changes.

Removed suitcase logo content to comply with BCBSA brand changes.

Added Mississippi and Wyoming to the BCBS Medicare Advantage PPO Network Sharing service areas.

Appendix 6-A Blue Shield Combined Eligibility/Capitation Report

Updated the report file layout.

Appendix 6-B Blue Shield Eligibility Adds and Terminations Report

Updated the report file layout.

Appendix 6-C Delegation Requirements for Claims and Oversight Monitoring

Key Terms and Definitions - Contested Claims (Commercial)

Added language:

Note: As defined by CCR Title 28, Section 1300.71(a)(9)-(12) DMHC clarification regarding the determination of financial responsibility between the Delegate and the Health Plan is not related to Medical Necessity per the below requirements.

(9) "**Health Maintenance Organization**" or "**HMO**" means a full service health care service plan that maintains a line of business that meets the criteria of Section 1373.10(b)(1)-(3).

(10) "**Reasonably relevant information**" means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.

(11) "**Information necessary to determine payer liability**" means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.

(12) "**Plan**" for the purposes of this section means a licensed health care service plan and its contracted claims processing organization.

Measuring Timeliness and Accuracy - Interest Accuracy (Commercial)

Removed language in strikethrough type: To avoid a mandated ~~\$10.00 per~~ claim penalty, the interest must be paid "automatically."

Removed language: For claims involving emergency services, the minim amount of interest due is the greater of either \$15.00 for each 12-month period or 15 percent per annum calculated as described above.

Measuring Timeliness and Accuracy - Measuring Timeliness (Commercial Claims)

Added and *removed* language in boldface and strikethrough type as follows: To fulfill the state regulations all denial notices must be mailed within ~~45 working~~ **30 calendar** days.

Measuring Timeliness and Accuracy - Unclean or Contested Claims (Commercial Contested)

Added and *removed* language in boldface and strikethrough type as follows: "The contested or pending claims must be closed prior to the ~~45th working~~ **30th calendar** day."

Best Practices and Claim Adjudication - Audits and Audit Preparation

Added language:

Blue Shield utilizes the HICE Claims Operational Questionnaire and participates via the HICE Claims Operational Questionnaire Repository. The Delegated Entity/Specialty Health Plan is required to submit the questionnaire through this repository. Completion of the HICE Claims Operational Questionnaire is required and provides detailed information about your claims processing operations and internal controls.

Added language: The written CAP must be submitted on a Blue Shield template provided by the auditor.

Best Practices and Claim Adjudication - Date Stamping

Added language:

If an MSO managing multiple Delegated Entities receives a claim through one of their post office boxes and inadvertently loads the claim into the wrong Delegated Entity/Specialty Health Plan's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity/Specialty Health Plan's claims system.

This would also apply to Electronic Data Interchange (EDI) claims. Delegated Entity/Specialty Health Plans must submit the 837 files associated with the selected claim sample to provide the raw data necessary for validation.

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