



601 12th Street
Oakland, CA 94607

April 22, 2026

Subject: Notification of July 2026 updates to the Blue Shield *Independent Physician and Provider Manual*

Dear Provider:

Blue Shield is revising the *Independent Physician and Provider 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 the *Guidelines & resources* tab.

You may also request a PDF version of the revised *Independent Physician and Provider Manual* 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 (Blue Shield) 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 that will be published in the July 2026 version of this Manual, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091.

Sincerely,

A handwritten signature in black ink that reads "Kimberli Robinson". The signature is written in a cursive, flowing style.

Kimberli Robinson
Vice President, Network Operations

blueshieldca.com

Updates to the July 2026
Independent Physician and Provider 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

Updated standard for regular and routine care PCP to 30 business days 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.

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.

Prior Authorization - Prior Authorization Response Times (Medical Services)

Updated Medicare Medical Services non-urgent response time from seven (7) business days to seven (7) calendar days.

Prior Authorization List for Network Providers 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.

Drug Formulary - Mandatory Generic Drug Policy

Removed the language in strikethrough as it is not currently a Blue Shield policy: 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- or biosimilar equivalent, in addition to the associated drug copayment.

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.

Electronic Claims Processing

Added language: There may be charges associated with electronic claims processing.

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).

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.

Mental Health and Substance Use Disorder Services

Added the following new section:

Mental Health and Substance Use Disorder Covered Services for Medicare Advantage Plan Members

Depending on their benefit plan and physician group, Blue Shield Medicare Advantage members may obtain covered MH/SUD services from a provider in one of the following ways:

1. Member's physician group:
 - a. A referral from their Primary Care Physician (PCP) is required.
 - b. Certain MH/SUD services may require an authorization.
2. Blue Shield directly-contracted network:
 - a. Members may self-refer. A referral from their PCP is not required
 - b. Certain MH/SUD services may require an authorization.

Blue Shield Medicare Advantage members can find a list of behavioral health providers in their printed Blue Shield provider directory, online via Blue Shield's *Find a Doctor* page or by contacting Blue Shield's Member Services at the number on the back of the member's ID card.

Covered MH/SUD services are the same as Original Medicare and include the following:

- o Outpatient Mental Health Services
- o Outpatient Substance Use Disorder Services
- o Opioid Treatment Program Services (OTP)
- o Inpatient Substance Use Disorder Services
- o Inpatient Services in a Psychiatric Hospital
- o Partial Hospitalization Services (PHP)
- o Intensive Outpatient Services (IOP)

Mental Health and Substance Use Disorder Services - Primary Care Physician Consultation Line

Removed the section. The consultation line is being retired due to inactivity from PCPs. Blue Shield will support PCPs and members with care management and referrals to Behavioral Health providers when needed.

Section 5: Blue Shield Benefit Plans and Programs (cont'd.)

Ancillary Benefits

Changed American Specialty Health Group, Inc. to American Specialty Health Plans.

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 1-B Blue Shield Combined Eligibility/Capitation Report

Updated the report file layout.

Appendix 1-C Blue Shield HMO Eligibility Adds and Termination Report

Updated the report file layout.

Appendix 2-A. Blue Shield Bylaws

Added latest version of Bylaws (1/1/25).

Appendix 4-A. Special Billing Guidelines and Procedures

Updated instructions for CMS 1500 Form Block 17.

Appendix 4-B Electronic Claims Submission

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

Appendix 4-C CMS 1500 General Instructions

Updated instructions for Block 17. Name of Referring Provider or Other Source.

Appendix 4-F. List of Office-Based Ambulatory Procedures

Deleted codes 0272T and 0273T.

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.