Blue Shield of California 50 Beale Street, San Francisco CA 94105

October 15, 2018

Subject: **Notification of January 2019 Updates to the Blue Shield *Independent Physician and Provider Manual***

Dear Provider:

We have revised our *Independent Physician and Provider Manual.* The changes listed on the following pages are effective January 1, 2019.

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 CD version of the revised *Independent Physician and Provider Manual* be mailed to you, once it is published, by emailing providermanuals@blueshieldca.com.

The *Independent Physician and Provider Manual* is referenced 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 January 2018 version of this manual, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091.

Sincerely,

Hugo Florez
Vice President, Provider Network Management,
Care1st and PPO Specialty Networks
Blue Shield of California

UPDATES TO THE JANUARY 2019
INDEPENDENT PHYSICIAN AND PROVIDER MANUAL

Section 1: Introduction

ENROLLMENT AND ELIGIBILITY

Blue Shield Enrollment Responsibilities to Members on the Exchange

Updated *language in boldface type below:*

Under the Patient Protection and Affordable Care Act (PPACA) for Exchange-purchased individual insurance policies eligible for premium subsidies, when premiums/dues are not received from members, there will be a three-month (90-day) **delinquency** period. During this grace period, Blue Shield may not disenroll **delinquent** members **but may suspend claims payments unless and until member premiums are received in full.** See Section 4: Special Billing Situations for Blue Shield's responsibilities regarding unpaid premiums for Exchange members.

MEMBER RIGHTS AND RESPONSIBILITIES

Updated *the Statement of Member Rights to align with Evidence of Coverage (EOC) language.*

Section 2: Provider Responsibilities

CREDENTIALING AND RECREDENTIALING

Blue Shield will begin using the California Participating Practitioner Application (CPPA) for credentialing and recredentialing applications beginning January 1, 2019. This form will appear on Provider Connection before the end of 2018 and may be used as soon as it is available.

Updated *in boldface type below:*

Blue Shield's credentialing program requires providers to submit all of the following:

1. A completed and signed approved application **and attestation to correctness.**

Added *the following to list of items that Blue Shield verifies for credentialing:*

6. Clinical privileges in good standing at a Blue Shield contracted hospital designated by the practitioner as the primary admitting facility, as appropriate, or a mechanism for another credentialed physician to cover the practitioner's patients when hospitalized; (through appropriate means of primary sources or by attestation from provider).

***Added** the following new section about CLIA program requirements:*

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) PROGRAM REQUIREMENTS

The CLIA mandates that all laboratories, including physician office laboratories, meet applicable Federal requirements and have a CLIA certificate to operate. The CLIA applies to all entities providing clinical laboratory services regardless of whether they or another provider file Medicare claims for the tests. Laboratories billing Medicare have additional responsibilities and requirements.

Blue Shield requires all professional and facility providers to adhere to the CMS and CLIA regulations and maintain a valid CLIA certification for the level of laboratory and/or pathology service they are providing. There are 5 different types of certification. Blue Shield requires any provider billing a laboratory or pathology service to maintain the CLIA certification for the specific test they are performing. For example, if a provider is billing a Q0111 Wet Mount, this provider would be required to have a current Provider Performed Microscopy Procedure (PPMP) certification in order to bill Blue Shield for payment.

***Added** the following new section detailing the Palliative Care Program:*

HOME-BASED PALLIATIVE CARE PROGRAM PROVIDERS

Enrolling/Disenrolling Members in the Home-Based Palliative Care Program

Assessing/Enrolling a Member

Home-based palliative care program providers are responsible for assessing whether a member qualifies for the program after a referral has been made. The assessment must be completed within fifteen (15) business days of the receipt of the referral or, in the case of a hospitalized member, within fifteen (15) days of the member's discharge from the hospital. If the referral is made by a Blue Shield case manager, the provider will receive the referral on a "Home Care Referral Event Form" (refer to Appendix 2 for a sample form), which will be sent via email. Upon receipt, the provider is asked to confirm that the form has been reviewed and the date of the scheduled assessment.

Conducting the Assessment

Blue Shield requires that home-based palliative care providers follow the current version of the *National Consensus Project's (NCP) Clinical Practice Guidelines for Quality Palliative Care, Domain 1: Structure and Processes of Care, Guideline 1.1 criteria*, when conducting the assessment (see Appendix 2).

The provider must notify Blue Shield via email to BSCPalliativeCare@blueshieldca.com within fifteen (15) business days of completing any assessment, whether received from a Blue Shield case manager or another avenue for referral, with the status of the member. If the member was referred by a Blue Shield case manager, an email must also be sent to the referring case manager with the status so that case management can be transitioned to the program provider, as applicable.

The status options are as follows:

- Enrolled, including the date of enrollment
- Accepted but not yet enrolled
- Not eligible
- Enrolled in hospice
- Declined enrollment

HOME-BASED PALLIATIVE CARE PROGRAM PROVIDERS *(cont'd.)*

Enrolling a Member

A notification of enrollment must be emailed to all the Blue Shield emails listed below within fifteen (15) days of a member's enrollment, as further described in the agreement.

- ShieldSupport@blueshieldca.com
- BSCPharmacyOperation@blueshieldca.com
- BSCPalliativeCare@blueshieldca.com

A program provider can recommend a member who does not meet the criteria be enrolled in the program by sending an email to BSCPalliativeCare@blueshieldca.com with an explanation for the recommendation along with supporting documentation.

Disenrolling a Member

Blue Shield must be notified of a member's disenrollment from the program within fifteen (15) days of the member's disenrollment, as specified in the agreement, via email sent to BSCPalliativeCare@blueshieldca.com. In addition to the information submitted upon enrollment, the provider shall also include the reason for the program member's disenrollment from the palliative care program.

Engaging the Palliative Care Team

The palliative care interdisciplinary team includes a physician who provides oversight, as well as a registered nurse (RN), case manager, social worker, home health aide, and chaplain. It may also include a physician assistant (PA), licensed vocational nurse (LVN), pharmacist, dietitian, rehabilitation specialist, physical therapist, etc.

In-person visits must be provided by the palliative care team's prescribing clinician at least once every three (3) months or when goals of care change. Above and beyond this requirement, the number and frequency of in-person and/or phone or video visits to a specific Blue Shield member in the program should be based on the medical, mental, emotional, social and spiritual needs of that patient. At minimum, each member of the palliative care team should contribute to the in-person assessment and the interdisciplinary team meetings.

Interfacing with Member's Treating Providers

The member's treating providers (e.g., PCP, oncologist, etc.) are an integral part of the palliative care team. Therefore, it is expected that the palliative care provider:

- co-develop and/or share palliative care plan with the treating provider(s),
- provide chart notes after every visit and advance care planning documents as completed or revised to treating provider(s),
- collaborate with the treating provider(s) to identify medications that optimally manage symptoms,
- ensure the treating provider(s) receives results on all outpatient orders,
- offer to include the treating provider(s) in palliative care conversations via online or phone conferencing, and
- document and retain records on all interactions with treating provider(s).

HOME-BASED PALLIATIVE CARE PROGRAM PROVIDERS *(cont'd.)*

Conducting Member and Family Satisfaction Surveys

Home-based palliative care program providers are responsible for delivering a member and family satisfaction survey to all members enrolled in the program on quarterly basis. The aggregated results must be reported to the Blue Shield Palliative Care Program Team within thirty (30) days of the end date of the collection period of the quarterly survey.

Participating in Quarterly Meetings

Blue Shield's Palliative Care Program Team will conduct quarterly meetings with each palliative care provider treating Blue Shield patients enrolled in the program. During this meeting, Blue Shield will review patient status, discuss issues, answer questions, provide support, and review quality criteria. Quality criteria for each member in the program includes but is not limited to:

- confirmation that a medical decision maker is on file,
- documentation of advance directive or POLST on file where appropriate,
- member and family satisfaction survey results; Blue Shield will work with providers to set acceptable targets, and
- discussion of any issues arising from Blue Shield's ongoing and systematic utilization review.

Blue Shield retains the right to audit provider participation in the program to ensure quality of care.

PROVIDER AVAILABILITY STANDARDS FOR COMMERCIAL PRODUCTS

***Updated** the Geographic Distribution table for the category of PCPs in boldface type below:*

The standard is one PCP within 15 miles **or 30 minutes** of each member.

***Updated** the Provider to Member Ratio table for the category of PCPs in boldface type below:*

The standard is one PCP to **2,000** commercial members.

LANGUAGE ASSISTANCE FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY (LEP)

*Blue Shield's threshold languages for 2019 are **Spanish, Chinese – Traditional, and Vietnamese.***

Medical Care Solutions Program Overview and Functions

Removed *pharmacists as part of the Blue Shield Medical Care Solutions professional staff and removed prior authorization of pharmaceuticals as a Medical Care Solutions function.*

Changed *the timeframe of which Blue Shield's Medical Care Solutions Department will contact the provider for urgent requests to inform them of the status of their request for care or services from 24 hours to 72 hours.*

Prior Authorizations

Added *the following prior authorization response times:*

Prior Authorization Response Times

Medical Services:

- Non-urgent, within five business days after receipt of request
- Urgent, within 72 hours after receipt of request if "urgent" criteria definition is met

Medications:

- Non-urgent, within 72 hours after receipt of request
- Urgent, within 24 hours after receipt of request if "urgent" criteria definition is met

Prior Authorization List for Network Providers

Added *prior authorization information for palliative care services, as follows:*

TYPE OF SERVICE / PROCEDURE	PPO AND DIRECT CONTRACT HMO
Home-based Palliative Care Services Not Included in the Program Case Rate *Note: Patients newly enrolled in the program are eligible for expedited authorization of certain covered services (e.g., supplies, durable medical equipment (DME), oxygen, medications).* ***Attach documentation that clearly states the member is in the Palliative Care Program and indicate that the request should be expedited.*** *If you need additional help in this area, email BSCPalliativeCare@blueshieldca.com.*	Prior authorization required (800) 541-6652 Option 6 Fax: (844) 807 8997 or Submit online with attached documentation, track, and receive determinations for medical authorizations via AuthAccel at blueshieldca.com/provider in the *Authorizations* section.

ORGAN AND BONE MARROW TRANSPLANTS

Updated *language in boldface type below:*

The following transplants are also eligible for coverage but are handled as routine inpatient services by the designated Medical Care Solutions Prior Authorization Department for all members. **No special centers are required as long as a Blue Shield of California contracted facility is used, and, for kidney transplants, the facility is Medicare-certified.**

- Cornea
- Kidney only
- Skin

DRUG FORMULARY

Updated *medication prior authorization for Commercial and Medicare as follows:*

Commercial Plans

Pharmacy Benefit Medications:

Providers have the option to complete and fax the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) to (888) 697-8122. This form is available on blueshieldca.com/provider under *Authorizations*, *Prior Authorization Forms and List*, *Prior Authorization Forms*, under the *Oral/Topical Drugs* link. Providers may also submit prior authorization requests online by going to blueshieldca.com/provider under *Authorizations* then *Request Pharmacy Prior Authorization.*

Outpatient Medical Benefit Medications:

Providers have the option to complete and fax the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) to (844)-265-5611. This form is available on blueshieldca.com/provider under *Authorizations*, *Prior Authorization Forms and List*, *Prior Authorization Forms*, under the *Office Drugs* link.

Medicare Plans

The Centers for Medicare & Medicaid Services (CMS) is eliminating the prescriber and provider enrollment requirement for Part C and Part D and instead is compiling a "Preclusion List" of prescribers, individuals, and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. CMS will make the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by, or associated with, prescriptions written by prescribers and providers on the list. Full enforcement of the Part C and D prescriber exclusion list requirement will begin on January 1, 2019.

Special Billing Situations

CRNA Billing

Updated *section for clarification with boldface type as follows:*

All CRNA claims must be billed with one of the Modifiers QS, QX or QZ, noted in the payment policy **for "Anesthesia Services"** located on Provider Connection, or the claim will be denied.

Office-Administered Injectable Medications

Added *the following language regarding a new Drop Ship program for select medications:*

Pharmaceutical supplies, including but not limited to, the drugs required to provide members with office- administered injectables are the responsibility of the physician and will be reimbursed by Blue Shield according to established allowed amounts for the services rendered to Blue Shield members. In addition, select medications are available for Drop Ship from a Blue Shield preferred pharmacy. Drop Ship is a voluntary program, in addition to the buy-and-bill method, for providers to procure office administered medications. The drop ship option will only be available for select drugs and does NOT replace buy and bill. Under this program, physician offices order medications from a Blue Shield preferred pharmacy on an individual patient basis. The pharmacy delivers the drug to the physician office and bills Blue Shield for the cost of the drug. After the member receives treatment, the physician only bills Blue Shield for the administration costs. Physician offices will continue to be required to procure medications through the buy-and-bill method for drugs not available through the Drop Ship program. A list of the Drop Ship medications and preferred pharmacies can be found on Provider Connection at https://www.blueshieldca.com/provider. For questions regarding billing of office administered injectable medications, please call Provider Information & Enrollment at (800) 258-3091.

Provider Appeals and Dispute Resolution

Removed *references to the Internal Control Number (ICN) and replaced with the Blue Shield assigned claim number as the way to identify a claim.*

Removed *references to ClaimCheck as it has been replaced with Claims Xten.*

MEDICARE PART D PRESCRIBER ENROLLMENT REQUIREMENT *has been changed to* MEDICARE PART D PRESCRIBER PRECLUSION LIST

*The section below has been **rewritten.** CMS has eliminated the Medicare Part D Prescriber Enrollment Requirement and replaced it with a Preclusion List.*

The Centers for Medicare & Medicaid Services (CMS) is eliminating the prescriber and provider enrollment requirement for Part C and Part D and instead is compiling a "Preclusion List" of prescribers, individuals, and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. CMS will make the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by, or associated with, prescriptions written by prescribers and providers on the list. Full enforcement of the Part C and D prescriber exclusion list requirement will begin on January 1, 2019.

Additionally, the added provisions require organizations offering Part D to cover a three-month provisional supply of the drug and provide beneficiaries with individualized written notice before denying a Part D claim or beneficiary request for reimbursement on the basis of a prescriber's being neither enrolled in an approved status nor validly opted out. The three-month provisional supply is intended to give the prescriber time to enroll in Medicare or opt-out and ensure beneficiary access to prescribed medication.

FEDERAL EMPLOYEE PROGRAM (FEP)

Precertification for Inpatient Hospital Admissions

***Updated** language in boldface type below:*

Preferred providers are responsible for obtaining pre-certification for all inpatient admissions to preferred hospitals. Pre-certification requires notification prior to scheduled admissions or within two business days after an emergency admission, even if the member has been discharged from the hospital within those 2 days. The member will be subject to the $500 benefit reduction if admitted to a preferred hospital and pre-certification is not obtained. The member is ultimately responsible for ensuring that pre-certification has been completed. If the pre-certification is not obtained, the member's inpatient hospital benefit for covered services will be reduced by $500. (For specific rules, please refer to Section 3 the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure located at Fepblue.org). Pre-certification is not needed for a maternity admission for a routine delivery. If the baby stays after the mother is discharged, then the physician must contact Blue Shield for pre-certification of additional days for the baby. **The subscriber must add the baby to the plan before certification for services to be provided.**

FEDERAL EMPLOYEE PROGRAM (FEP) *(cont'd.)*

***Added** the following new section:*

Required Prior Authorization

Members must obtain prior approval for these services under both the Standard and Basic Option. Precertification is also required if the service or procedure requires an inpatient hospital admission. Contact Blue Shield at the prior authorization number at (800) 633-4581 before receiving these types of services. Find more information about the services below in the BCBSA Service Benefit Plan (SBP) Brochure at https://www.fepblue.org/benefit-plans/benefit-plans-brochures-and-forms.

Prior Approval is required for:	Additional Information
Outpatient sleep studies performed outside the home	Prior approval is required for sleep studies performed in any other location that is not the member's home.
Applied behavior analysis (ABA)	Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
Gender reassignment surgery	Prior to surgical treatment of gender dysphoria, the provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and is later modified. Modification can be to the type of treatment, date, time or location of the service/surgery to be provided.
BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes	Prior approval is required for BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes whether performed for preventive or diagnostic reasons. *Note:* Genetic counseling and evaluation services are required before *preventive* BRCA testing is performed.
Surgical services	Morbid Obesity - See the 2018 Service Benefit Plan Brochure for requirements. Surgical correction of congenital anomalies (see definition in the Service Benefit Plan Booklet); and surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth (see definition in the Service Benefit Plan Brochure). Separate Inpatient (IP) Authorization is needed for all IP admissions.
Hospice care	Prior approval is required for home hospice, continuous home hospice, or inpatient hospice care services. Blue Shield will advise you which home hospice care agencies we have approved. Please contact FEP Care Management at (800) 995-2800.
Organ/tissue transplants – Prior approval is required for both the procedure and the facility	Covered Organ/tissue Transplants - See the list of covered transplant services in the 2018 Service Benefit Plan Brochure. If you travel to a Blue Distinction Center for Transplants, prior approval is also required for travel benefits. The organ transplant procedures must be performed in a facility with a Medicare-Approved Transplant Program. If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply, and you may use any covered facility that performs the procedure. The blood or marrow stem cell transplants listed must be performed in a facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT), or in a facility designated as a Blue Distinction Center for Transplants or as a Cancer Research Facility. Clinical trials for certain blood or marrow stem cell transplants – See the list of conditions covered only in clinical trials in the 2018 Service Benefit Plan Brochure.

Prescription drugs and supplies	Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: 800-624-5077 for the hearing impaired) or visit the FEP CareMark website at: https://www.caremark.com/wps/portal/WEBSUPPORT_FAQS?cms=CMS-PWCM-2034779 to request prior approval, or to obtain a list of drugs and supplies that require prior approval. Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change.
Mail Order Prescription Drug Program	Standard Option members may use our Mail Service Prescription Drug Program to fill their prescriptions. Basic Option members with primary Medicare Part B coverage also may use this program once prior approval is obtained.
Medical foods covered under the pharmacy benefit	Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: 800-624-5077 for the hearing impaired) to request prior approval.

Added *the following new section detailing mental health services:*

MENTAL HEALTH SERVICES

Psychiatric Care

The diagnosis and medically necessary treatment of mental health conditions are a covered benefit for all Blue Shield plans. Severe mental illness and serious emotional disturbances of a child for all commercial members are covered under the same terms and conditions as any medical condition. Blue Shield's mental health service administrator (MHSA) for commercial PPO members is Human Affairs International of California (HAI-CA). Other psychiatric conditions are also covered through the MHSA.

Members must utilize the Blue Shield MHSA provider network to access psychiatric covered services and receive authorization for these services from the MHSA.

Commercial PPO members should use the Member Self-Referral phone number below to contact Blue Shield's MHSA to access behavioral health care.

Member Self-Referral Number

Blue Shield members can self-refer to the MHSA by calling the Member Self-Referral Number at (877) 263-9952 to obtain a referral to an appropriate mental health provider and receive an authorization for services and/or crisis intervention services. This phone number is available 24 hours/day; 7 days per week, 365 days a year.

Primary Care Physician Consultation Line

The Blue Shield MHSA offers a Primary Care Physician Consultation Line at (877) 263-9870 to facilitate Personal Care Physician discussion with a Board-Certified psychiatrist regarding mental health and substance abuse issues, prescribing of psychotropic medication and coordination of care issues.

PCP Behavioral Health Toolkit

Primary care physicians and their staff members can access Blue Shield's new online PCP Behavioral Health Toolkit at any time by visiting blueshieldca.com/provider, selecting the *Guidelines & Resources* tab, then clicking *PCP Behavioral Toolkit* under the *Patient Care Resources* section. The website includes clinical consultation contacts, referral information, screening tools, patient education resources and more to help primary care physicians manage or refer patients to meet behavioral health care needs.

MENTAL HEALTH SERVICES *(cont'd.)*

Telebehavioral Health Online Appointments

The Blue Shield MHSA offers real-time, two-way communication via online virtual appointments with a mental health or substance use disorder provider. Appointments are available for counseling services, psychotherapy, and medication management with participating therapists and psychiatrists contracted with Blue Shield's mental health service administrator (MHSA). To access Telebehavioral health providers, members can visit *Find a Doctor* on blueshieldca.com. Once on *Find a Doctor*, click on *Mental Health* to be directed to Blue Shield's MHSA website. Enter the required search criteria, hit search and on the next screen click on *More Filters*, then select *Telebehavioral Health* from the Specialties drop down list.

Blue Shield Mental Health Service Administrator (MHSA) Covered Services for PPO Commercial Plan members

Blue Shield's MHSA is responsible for authorizing services and paying claims for the following services:

- In-network professional and institutional psychiatric services.
- Pre-surgical Psychiatric/Psychological evaluations requested by the surgeon.
- Outpatient services for the treatment of mental health diagnoses when provided by a MHSA contracted clinician.
- Electro-convulsive Therapy (ECT) and associated anesthesia.
- Transcranial Magnetic Stimulation – A non-invasive method of delivering electromagnetic stimulation treatment to the brain for the treatment of depression.
- Behavioral Health Treatment (BHT) including Applied Behavior Analysis (ABA).
- Inter-facility transports authorized by the MHSA.
- Psychological testing for a psychiatric condition.

For the following other services, please see member's health plan benefits:

- Outpatient radiology, laboratory, speech therapy, occupational therapy, and physical therapy services associated with a psychiatric diagnosis.
- Medical consultations requested by the MHSA.
- Structured Pain Management Program.
- Nutritional counseling.
- Experimental or investigational treatments.
- Outpatient prescription medications.

Mental Health Services for Self-Funded Accounts (ASO) and the Federal Employee Program (FEP)

Self-Funded Accounts (ASO) and the Federal Employee Program (FEP) use Blue Shield of California's network of contracted mental health providers. Claims are billed to Blue Shield.

For additional mental health information for ASO and FEP accounts, see the following sections within this manual:

Section 2: Behavioral Health Requirements – FEP PPO and ASO

Section 3: Mental Health and Substance Use Disorder Clinical Management Program for Self-Insured Accounts (ASO)

Section 5: Federal Employee Program (FEP); Mental Health, Substance Abuse, and Behavioral Health Services for FEP

Disease Management

*This section was **removed.** Disease Management will be integrated into the Shield Support Care Management program on 1/1/19. The chronic condition language was added to the Care Management section.*

Case Management *has been changed to* Care Management

***Added** "behavioral health clinicians" to list of providers that make up the Shield Support care teams.*

***Updated** the conditions that the Shield Support program encompasses, as follows:*

Shield Support encompasses a broad spectrum of interventions for short-term care coordination as well as ongoing complex case management for members with the following conditions or utilization:

- Behavioral health
- Cancer
- Cardiovascular, *e.g.*, Coronary Artery Disease, Heart Failure
- Catastrophic injury
- Diabetes
- Musculoskeletal
- Chronic Pain
- Respiratory, *e.g.*, Asthma, COPD
- End-stage renal disease
- Stroke
- Transgender
- Transplant (solid organ and bone marrow)
- Pre-term infants in the Neonatal Intensive Care Unit (NICU) and post NICU
- Plus: ER utilization, post-discharge from hospital, opioid use, high cost and direct referrals

The following services are offered through the Shield Support Care Management Program:

- Telephonic coaching from nurses, behavioral health clinicians, social workers and pharmacists
- Home visits (as needed)
- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- In-person self-management community workshops (for members 18+ years of age)
- Virtual health coaching and cognitive behavioral therapy modules
- Online self-management workshops and educational materials (for members 18+ years of age)

Physician referrals are an important component of Blue Shield's Care Management Programs and may allow for identification of a member more quickly. Blue Shield providers may refer Blue Shield members to our Care Management Programs by submitting the referral form via secure email to bscliaison@optum.com or fax to (877) 280-0179. To download an electronic copy of the referral form, please visit www.blueshieldca.com/provider/guidelines-resources/patient-care/programs.sp. Each referral will be evaluated for eligibility and appropriateness

Musculoskeletal Case Management

*This section was **removed.** Musculoskeletal Case Management will be integrated into the Shield Support Care Management program on 1/1/19 and the program language added to the Care Management section.*

CARE MANAGEMENT *(cont'd.)*

Additional Care Management Programs

The Health Advocate program name was ***changed*** *to Shield Advocate.*

Behavioral Health Condition Management

This section was ***removed.*** *Behavioral Health Condition Management will be integrated into the Shield Support Care Management program on 1/1/19 and the program language added to the Care Management section.*

Added *the following new program:*

Landmark Home-Based Care. The Landmark program offers participating chronically ill members 24/7 access to medical professionals and in-home urgent care. Community-based, physician-led medical teams specializing in house calls and home-based care deliver medically needed services to chronically ill patients. Landmark does not replace patients' primary care providers but rather supports the work of patients' existing providers. Landmark clinicians communicate and collaborate with the patients' PCPs and specialists to reinforce the PCP's in-office care plan and provide the attention and care that chronically ill patients with complex health needs may require. Blue Shield identifies eligible members for the Landmark program based on their health and the number and type of chronic conditions they have.

Added *the following new section detailing the palliative care program:*

HOME-BASED PALLIATIVE CARE PROGRAM

Blue Shield offers a home-based palliative care program that uses an interdisciplinary team to provide tightly integrated, longitudinal in-home palliative care services as well as the assessment and provision of medical care aligned with the patient's goals. The program incorporates:

- treatment decision support,
- care plan development and shared decision-making, and
- pain and symptom management.

Services provided under the program include, but are not limited to:

- comprehensive in-home, palliative care needs assessment,
- care plan development aligned with the member's goals,
- nurse case manager assignment to coordinate medical care,
- home-based palliative care visits - either in person or via videoconferencing,
- medication management and reconciliation,
- psychosocial support for mental, emotional, social and spiritual well-being,
- 24/7 telephonic support,
- caregiver support, and
- transition assistance across care settings (*Note:* A member remains enrolled in the program during admission to and discharge from any facilities where the member seeks care).

Members do not need to be terminal nor forego curative treatment to qualify for the program. Members most likely to benefit from the program include those in remission, recovering from serious illness or in the late stage of illness; those experiencing documented gaps in care including a decline in health status and/or function; and those using the hospital and/or the emergency room to manage illness/late-stage disease.

HOME-BASED PALLIATIVE CARE PROGRAM *(cont'd.)*

Eligibility/Referral

The home-based palliative care program is available to all Blue Shield members except for those covered under a PPO Federal Employee Plan (FEP), a Blue Shield Medicare supplemental insurance plan (Medigap), or those currently enrolled in hospice or who have an illness that is primarily a psychiatric or substance use disorder. Members with one of the following diagnosis categories, among others, are appropriate for the program: cancer, organ failure, stroke, neurodegenerative disease, HIV/AIDS, dementia/Alzheimer's, frailty or advance age, and/or multiple comorbidities.

Referral to the program can be made in one of three ways: (1) members can self-refer to the program by contacting Blue Shield Member Customer Service at the phone number located on the back of the member ID card, (2) medical care providers can refer members to the program by contacting Blue Shield Provider Customer Service at (800) 541-6652, or (3) Blue Shield case managers can refer members to the program.

Once a referral is made, the member will be screened to determine whether or not the criteria outlined in the Palliative Care Patient Eligibility Screening Tool (see Appendix 2) is met, then the member can decide whether or not to participate in the program. Enrollment in the program does not eliminate nor reduce any covered benefits or services, including home health services.

WELLNESS AND PREVENTION PROGRAMS

Added *the following new program:*

Diabetes Prevention Program

The Diabetes Prevention Program helps members who are at risk of type 2 diabetes lose weight and adopt healthy habits. The program includes 16 weekly sessions over the span of six months followed by monthly maintenance sessions during which members will learn new ways to eat healthier, increase activity, and manage challenges with help from a personal health coach and a small support group. The program is digital or in-person. Members can get started by pre-qualifying at www.solera4me.com/shield.

Appendices

Added *the following new appendices relating to the palliative care program:*

APPENDIX 2-B BLUE SHIELD HOME CARE REFERRAL FORM

APPENDIX 2-C NATIONAL CONSENSUS PROJECT (NCP) CLINICAL PRACTICE GUIDELINES FOR QUALITY PALLIATIVE CARE

APPENDIX 2-D PALLIATIVE CARE PATIENT ELIGIBILITY SCREENING TOOL

APPENDIX 4-B ELECTRONIC CLAIMS SUBMISSION

***Expanded** the following sections describing EDI resources available on Provider Connection:*

EDI Claims Status Inquiries (276)

Providers use the EDI Claim Status Inquiry transaction (EDI 276) to inquire about the status of a claim after it has been submitted to Blue Shield. The claim status response transaction (EDI 277) is then returned in response to a request inquiry about the status of a claim. The claim status response (EDI 277) indicates if a claim is pending or finalized. If finalized, it states the disposition of the claim – rejected, denied, approved for payment, or paid.

If the claim was approved or paid, payment date, amount, etc. may also be provided in the 277. If the claim was denied or rejected, the 277 includes an explanation, such as if the subscriber is not eligible. Benefits of using EDI Claim Inquiry are:

- Increase efficiency by tracking claims in seconds eliminating unnecessary claims tracing
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce accounts receivable days outstanding by receiving responses the next business day

To enroll for the EDI Claim Status Inquiries, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in Electronic Data Interchange*, contact the EDI Department at (800) 480-1221, or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry.

EDI Eligibility Inquiries (270/271)

The EDI Eligibility and Benefit inquiry (EDI 270/271) is used to verify information about the healthcare eligibility and benefits associated with a subscriber or dependent. The eligibility and benefit response (EDI 271):

- Checks member eligibility and benefits within seconds
- Provides correct member demographic information
- Verifies member liability and accumulated amounts including copays, deductibles, and out-of-pocket expenses
- Confirms member coordination of benefits (COB) information

Advantages of checking member eligibility and benefits are:

- Fewer rejected claims
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce collection and billing costs

To enroll for the EDI Eligibility Inquiries, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in Electronic Data Interchange* or contact the EDI Department at (800) 480-1221.

Appendix 4-B Electronic Claims Submission *(cont'd.)*

EDI Authorizations (278)

Blue Shield offers health care providers the ability to submit request for prior authorization, (e.g., preapproval, preauthorization, prior notification, etc.) review, and receive responses electronically. This allows the provider to:

- Track records more easily when you receive documentation of authorization requests
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce the potential for patient care delays associated with prior authorization

To enroll for EDI Authorizations, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in Electronic Data Interchange* or contact the EDI Department at (800) 480-1221.

***Added** the following method of receiving claims transmissions:*

Real-time HTTP/s Connectivity

Blue Shield supports CORE Phase II HTTP/s open connectivity standards, HTTP MIME Multipart and SOAP+WSDL for EDI eligibility and claim inquiries.

***Removed** the section entitled* **Validation Reports**. *Blue Shield no longer mails this report to submitters when a claim is submitted to Blue Shield electronically.*

Appendix 4-H List of Office-Based Ambulatory Procedures

***Added** the following codes:*

31298	Nasal sinus endoscopy surgical
36465	Inj noncompounded foam sclerosant
36466	Inj noncompounded foam sclerosant
0465T	Supchrdl njx rx w/o supply
0474T	Insj aqueous drg dev io rsvr
0482T	Absolute quant myocardial bld flow

***Removed** the following codes:*

0299T	Esw wound healing init wound
0300T	Esw wound healing addl wound

Appendix 5-B Other Payor Summary List

For the most current list, go to Provider Connection at blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards, then Other Payor Summary List.

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