601 12th Street
Oakland, CA 94607

October 14, 2022

Subject: **Notification of January 2023 Updates to the Blue Shield *Hospital and Facility Guidelines***

Dear Provider:

We have revised our *Hospital and Facility Guidelines.* The changes listed in the following provider manual sections are effective January 1, 2023.

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* be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *Hospital and Facility Guidelines* is referenced 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* 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 January 2023 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

UPDATES TO THE JANUARY 2023 HOSPITAL AND FACILITY GUIDELINES

General Reminders

Please visit Provider Connection at blueshieldca.com/provider for updated Forms, Member Rights and Responsibilities, Authorizations, Claims information, Provider Manuals and much more.

Section 1: Introduction

Member Rights and Responsibilities – Blue Shield HMO and PPO Commercial Members

Statement of Member Rights

Updated Member Rights and Responsibilities to align with current *Evidence of Coverage* (EOCs).

Blue Shield Medicare Advantage Compliance Program

Deleted Medicare Compliance Managers, staff of compliance analysts and auditors, and delegated claims compliance and performance auditors from the list of team members who advise about CMS requirements and who monitor compliance within the organization and in relation to Blue Shield's representatives in the community.

Section 2: Hospital and Facility Responsibilities

Provider Responsibilities for Quality Management and Improvement

Deleted and ***replaced*** list of Quality Management and Improvement activities that Blue Shield solicits its providers to participate in, as follows:

- QI Committees
- Credentialing, peer review, and utilization management determinations
- Clinical QI workgroups
- Focus groups
- QI studies
- Investigation of member grievances and quality of care issues

Submission of Laboratory Results Data

Updated the contact information for the HEDIS Supplemental data team to HEDISSUPPDATA@Blueshieldca.com.

Quality of Care Reviews

Added language to indicate that contracted facilities are obligated to participate in the quality of care review process and must provide medical records and corrective action plans, upon request.

Service Accessibility Standards for Commercial and Medicare

Behavioral Health Geographic Access Standards

Deleted and ***replaced*** cells containing information about access standards for behavioral health providers with the following cells:

CATEGORY	ACCESS STANDARD	COMPLIANCE TARGET
Geographic Distribution of Behavioral Health Individual Practitioners including: - Psychiatrists - Psychologists - Master's Level Therapists	Urban: 1 within 10 miles of each member Suburban: 1 within 20 miles of each member Rural: 1 within 30 miles of each member	Urban: 90% Suburban: 85% Rural: 75%
Behavioral Health Member Ratio including: - Top 3 HVS and Substance Use practitioner	1 provider of each type (i.e., Psychologists, Psychiatrists, or Master's Level Therapists) to 20,000 members	100%

Provider Availability Standards for Commercial Products

Deleted and ***replaced*** with the following sections of the Geographic Distribution chart:

CATEGORY	PRODUCT TYPE	STANDARD	COMPLIANCE TARGET
Pharmacy		One Pharmacy in 10 miles	90%

Provider-to-Member Ratio

Deleted and ***replaced*** with the following cells in the chart:

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
Top High-Volume Specialties and High-Impact Specialties to Member Ratio	HMO PPO-DMHC IFP-ePPO	1 OB/GYN to **5**,000 female members. 1 High-Volume Specialty of each type and 1 High-Impact Specialty to **10**,000 members.	100%

Linguistic and Cultural Requirements

Updated language in chart to reflect that the language threshold for PCPs is 1,200 members.

Additional Measurements for Multidimensional Analysis for Commercial Products

Deleted and ***replaced*** with the following cells in the chart:

METRICS	PRODUCT	STANDARD	FREQUENCY
Access and availability related member complaints and grievances	HMO/POS/ PPO	Rate of complaints/grievances ≤1 per thousand members per month (non-Medicare) Rate of complains/grievances ≤5 per thousand members per month (Medicare)	Assessed Quarterly against Standard
PCP Turnover	HMO/POS	10% change	Assessed Quarterly against Standard
Open PCP Panel	HMO/POS/ Directly Contracted HMO	70%	Assessed Quarterly against Standard

Additional Measurements for Multidimensional Analysis for Medicare Advantage Products

Deleted and ***replaced*** with the following cells in the chart:

METRICS	COMPLIANCE TARGET	FREQUENCY
PCP Turnover Rate	10%	Semi-Annual

Use of Non-Preferred/Non-Participating Providers

Facility Directory

Deleted and ***replaced*** with the following language:

Blue Shield maintains a directory of Blue Shield Providers that is made available to members.

In preparation for inclusion in Blue Shield's Directory publications the facility is required to attest to the accuracy of their data every 90 days in compliance with the 2020 Consolidated Appropriations Act (CAA) All providers with a contracted relationship with Blue Shield will display in the Blue Shield *Find a Doctor* online directory.

Facilities have an opportunity to leverage Provider Connection online tools to support the process of attestation and submitting provider directory information updates. Non-responsive providers will be suppressed from the directory until they have attested to their information.

There are two ways to update data:

1) Make changes directly on Provider Connection in the Provider & Practitioner Profiles section;
2) Download your data via Provider Data Validation Spreadsheet and upload revisions to the site.

To discuss the information shared about your organization in the Blue Shield *Find a Doctor* online directory, please contact the Provider Information and Enrollment team at (800) 258-3091, from 6 a.m. to 6:30 p.m., Monday through Friday.

In order to reduce administrative burden on providers, Blue Shield may delegate some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the facility may work with the vendor in lieu of Blue Shield to complete directory maintenance tasks.

Section 3: Medical Care Solutions

Medical Care Solutions Program Overview

Added language to indicate that Blue Shield has developed Medical Care Solutions processes that monitor care management.

Medical Necessity Denials

Updated paragraph language in boldface type, as follows:

When a hospital admission, continued stay, pharmaceutical/drug, or proposed service is determined to be not medically necessary or not covered under the member's plan, **a peer-to-peer request is made to discuss the plan of care with the attending clinician. A determination is made within 72 hours of the request and** the facility / attending physician is

notified by phone or fax within 24 hours of the decision. Written notification of the denial is also sent to the member or responsible party, the attending physician, and the hospital. Notification for routine pre-service requests is within two business days of making the decision. For urgent requests, notification is within 72 hours of receipt of requests.

Blue Shield Medical & Medication Policies

Medication Policy

Deleted and ***replaced*** the list of criteria for pharmaceuticals to be eligible for coverage, as follows:

For a pharmaceutical to be considered eligible for coverage, the drug product must meet the following criteria:

1. The pharmaceutical product is approved by the U.S. Food and Drug Administration for marketing in the U.S.
2. The formulary placement and medication coverage policy recommendations are based on the principles of evidence-based medicine, which is a review of scientific evidence from peer-reviewed published medical literature.
   a. Multi-center, randomized, prospective clinical trial results published in the peer-reviewed literature demonstrating the treatment to be at least as safe and effective as other established modalities of therapy are considered as best evidence.
   b. In absence of randomized controlled trials, lesser level of evidence, such as observational studies, medical society guidelines, and accepted community standard of practice will be considered.

Section 4: Billing and Payment

Claims Submission

Reference Materials

Added the following definition:

ASP - ASP refers to the Average Sales Price is a market-based price that reflects the weighted average of all manufacturer sales prices that includes all manner of discounts. The ASP is issued by CMS quarterly based on the information submitted by the manufacturer and is a reference point to estimate acquisition costs.

Special Billing Situations

Added the following new section:

Genetic and Molecular Testing

A procedure description is required for Unlisted Genetic and Molecular Testing procedure codes with use of the Genetic Testing Unit (GTU). The specific GTU for each procedure code can be identified by accessing Concert Genetics Provider Portal at www.concertgenetics.com/join-blue-shield-california. Providers are required to bill according to the CPT coding established in

the Concert Genetics portal.

Claim Type	Field or Segment	GTU Format
837I Transaction Institutional Claims	Loop 2400 segment SV202-7	Insert the exact GTU or the GTU preceded by "GTU-." For example, insert either: • 6V98G • GTU-6V98G
UB-04 Form Institutional Claims	Form Locator 80	

Provider Appeals and Dispute Resolution

Unfair Billing and Payment Patterns

Added the following language as part of instructions for submitting an initial and final appeal:

Please submit on paper only. Digital media such as compact discs, USB data keys, flash drives, and other digital formats are not permissible. Submission of digital media will not be effective to initiate an appeal, and any digital media received by Blue Shield will be destroyed without review or further notice to the submitting party.

Section 5: Blue Shield Benefit Plans and Programs

Medicare Part D

Medication Therapy Management Program (MTMP)

Updated list of criteria members must meet in order to qualify for MTMP, as follows:

- Have **three** of the following conditions:
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Hypertension
  - Osteoporosis
  - Respiratory Disease
- Receive **eight** or more different covered Part D maintenance medications monthly

Blue Shield PPO Plans

Added the following language to paragraph about digital care delivery:

The Virtual Blue PPO plan uses remote, digital engagement as the default care delivery method when appropriate. Members have access to virtual primary care and specialist care, including psychiatry and psychology. A care team consisting of a virtual PCP, health coach and behavioral health specialist help members get the care they need. When in-person care is either preferred by the member or referred to by the care team, members have access to any provider in their PPO network.

Blue Shield Medicare (PPO) (Medicare Advantage)

Individual Blue Shield Medicare (PPO) Service Area

Added Orange and San Diego Counties to the Individual Blue Shield Medicare (PPO) Service Area.

Federal Employee Program (FEP)

Mental Health and Substance Use Disorder Services for FEP

Updated language to indicate that telehealth visits were added to the list of types of outpatient professional service visits, for which a prior authorization is not required.

Required Prior Authorization

Deleted the following paragraph about prior authorizations for transplants, prescription drugs and supplies and medical food:

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 (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.

Deleted the following paragraph about prior authorizations for specialty DME, Gene Therapy and Cellular Immunotherapy, Air Ambulance Transport (Non-Emergent), Outpatient Intensity Modulated, Radiation Therapy (IMRT), Rehabilitation Services Devices, Outpatient Residential Treatment Center Care and High tech Radiology:

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 (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.

Medicare Supplement Plans

Claims Assignment

Moved "Benefit Plan G" to the section of the pay structure table to which Blue Shield pays 100% of the difference between Medicare's payment and billed charges.

Wellness and Prevention Programs

Deleted the CareTips Clinical Messaging section as this is no longer a program that Blue Shield supports.

Wellness and Prevention Programs

LifeReferrals 24/7℠

Updated language to indicate that members can talk to a referrals specialist and set up 3 sessions with a licensed therapist, in any six-month period, at no cost.

Wellness and Prevention Programs

Revised entire section to reflect changes in our Wellvolution Program.

Added the following bullet point in list of programs offered through Wellvolution:

- Mental Health Programs – To support our members in achieving optimal whole person health, our mental health programs are perfect for members that are seeking opportunities to incorporate everyday mindfulness into their daily lives to reduce stress, increase resilience, and get a better night's rest as well as for members seeking support for low- to moderate- anxiety or depression. Programs include guided meditations, sleepcasts, mindfulness exercises, 24/7 Behavioral Health coaching, personalized care plan, and more.

Appendices

Appendix 4-D List of Incidental Procedures

Deleted the following procedure codes:

0290T	Laser inc for pkp/lkp recip
0356T	Insrt drug device for iop

Appendix 4-E List of Office-Based Ambulatory Procedures

Added the following procedure codes:

42975	Dise eval slp do brth flx dx
53454	Tprnl balo cntnc dev adjmt

Deleted the following procedure code:

0551T	Tprnl balo cntnc dev adjmt

Appendix 5-A The BlueCard Program

Updated Out-of-State to Other State throughout Appendix 5-A.

Updated BLUEHPN to BlueHPN throughout Appendix 5-A.

Coverage and Eligibility Verification

Added new paragraph about Eligibility and Benefits for BlueHPN EPO Members, below:

Eligibility and Benefits for BlueHPN EPO Members

BlueHPN EPO members will be identified as such within the eligibility and benefits result response. If you are a Blue Shield of California contracted provider within BlueHPN network, submit your claim to Blue Shield. If you are not a contracted BlueHPN provider with Blue Shield of California, you should be aware that the only services that are covered for BlueHPN EPO members are urgent and emergent care outside of BlueHPN product areas. Benefits are determined by Blue plan the member is insured with.

Types of Medicare Advantage Plans

Deleted the following bullet point in the list of Medicare Advantage PFFS characteristics:

- You can determine the Terms and Conditions related to a members' Medicare Advantage Plan by accessing the Medicare Advantage Plan Terms and Conditions Lookup Tool located under the Find BlueCard Program Resources link on the BlueCard Program page at blueshieldca.com/provider. To use the tool, enter the first three characters of the member's identification number on the Blue Cross Blue Shield Medicare Advantage PFFS card and click "GO" to view the BCBS Medicare Advantage PFFS Plan's Terms & Conditions.

Medicare Advantage Medical Savings Account (MSA)

Deleted and ***replaced*** with the following language:

A Medicare Advantage MSA plan is made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills

Medicare Advantage PPO Network Sharing

Deleted and ***replaced*** the Medicare Advantage Network Sharing section with below:

What is BCBS Medicare Advantage PPO Network Sharing?

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted MA PPO provider.

What does the BCBS Medicare Advantage (MA) PPO Network Sharing mean to me?

If you are a contracted MA PPO provider with Blue Shield and you see MA PPO members from other BCBS Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Shield contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with Blue Shield of California and you provide services for any BCBS MA members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a MA PPO member when their member ID card has the following logo.

The "MA" in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Do I have to provide services to Medicare Advantage PPO members from other Blue Cross Blue Shield Plans?

If you are a contracted Medicare Advantage PPO provider with Blue Shield of California, you must provide the same access to care as you do for Blue Shield MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local Blue Cross Blue Shield Medicare Advantage PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

What will I be paid for providing services to these out-of-area Medicare Advantage PPO network sharing members?

If you are a MA PPO contracted provider with Blue Shield, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, Blue Shield will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to Medicare Advantage out-of-area members not participating in the Medicare Advantage PPO Network Sharing?

When you provide covered services to other BCBS MA out-of-area members', benefits will be based on the Medicare allowed amount. Once you submit the claim, Blue Shield will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.

May I request payment upfront?
Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, co-payment, coinsurance, and non-covered services).

Under certain circumstances when the member has been notified in advance that a service will not be covered, you may request payment from the member before services are rendered or billed to the member. The member should sign an Advance Benefit Notification (ABN) form before services are rendered in these situations.

What is the member cost sharing level and co-payments?

Member cost sharing level and co-payment is based on the member's health plan.
You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at (800) 676-BLUE (2583).

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact Blue Shield at (800) 622-0632.

What is BCBS Medicare Advantage PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO BCBS Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted MA PPO provider. MA PPO shared networks are available in 39 states and one territory:

Alabama	Kentucky	Nebraska	Puerto Rico
California	Kansas	Nevada	Rhode Island
Colorado	Louisiana	New Hampshire	South Carolina
Connecticut	Maine	New Jersey	Tennessee
Florida	Massachusetts	New Mexico	Texas
Georgia	Michigan	New York	Utah
Hawaii	Minnesota	Ohio	Virginia
Idaho	Missouri	Oklahoma	Washington
Illinois	Montana	Oregon	Wisconsin
Indiana	North Carolina	Pennsylvania	West Virginia

Deleted the entire Medicare Advantage SNP Section.

Added entire Medicare Advantage Coordination of Care Program section, as follows:

Medicare Advantage Coordination of Care Program

A new national Coordination of Care program to support Blue MA members was launched on January 1, 2020. The program aims to increase the quality of members' care by enabling Blue MA PPO group members to receive appropriate care, wherever they access care.

To better support all Blue MA PPO group members residing in California, Blue Shield is working with providers to improve these members' care through:

- Supporting providers with additional information about open gaps in care
- Requesting medical records to give Plans a complete understanding of member health status

MA PPO group members participating into this program can be identified as having a member address in California and based on the following logo included on their Blue Cross and/or Blue Shield ID Cards:

What does this new program to support Blue Medicare Advantage members mean to me?

This program will result in some changes, including a number that will be beneficial to you, your practice and your patients. The program serves all MA PPO group members that reside in Blue Shield's service area, and some of the benefits that you may see include:

- You will receive consolidated information on gaps in care and risk adjustment gaps, as well as medical record requests for all Blue MA PPO members enrolled with Blue Shield and other Blue Plans and residing in California through local communication practices.
- The MA PPO group members that you see may come into your practice setting more frequently for care due to Blue Shield's requesting care gap closures, allowing for greater continuity in care.

Reminder: As outlined in your contract with Blue Shield, you are required to respond to requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. This includes requests from Blue Shield related to this program.

Health Insurance Marketplaces Overview

Deleted the section on OPM Multi State Plan Program.

Appendix 5-B Other Payor Summary List

Updated summary list. For the most current list, go to Provider Connection at blueshieldca.com/provider and click on *Guidelines & resources, Policies and standards*, then *Other Payor Summary List* on the left.

Appendix 6-C Claims, Compliance Programs, IT System Security, and Oversight Monitoring

Measuring Timeliness

Added the following language about processing claims that are entered into the wrong claims system:

If a Management Service Organization (MSO), that manages several delegated entities, receives a claim from one of their post office boxes and loads the claim into the wrong Delegated Entity's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity's claim system.

Claims Delegate Reporting Instructions

Deleted and ***replaced*** to include updated instructions on how to submit reports, report naming conventions, submission schedules and sample reports.