601 12th Street
Oakland, CA 94607

October 16, 2024

Subject: **Notification of January 2025 updates to the Blue Shield *HMO IPA/Medical Group Procedures Manual***

Dear IPA/medical group:

Blue Shield is revising the *HMO IPA/Medical Group Procedures Manual* (Manual). The changes in each provider manual section listed below are effective January 1, 2025.

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 *HMO IPA/Medical Group Procedures Manual* be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *HMO IPA/Medical Group Procedures Manual* is included by reference in the agreement between Blue Shield of California (Blue Shield) and those IPAs and medical groups contracted with Blue Shield. If a conflict arises between the *HMO IPA/Medical Group Procedures Manual* and the agreement held by the IPA or medical group and Blue Shield, the agreement prevails.

If you have any questions regarding this notice or about the revisions to be published in the January 2025 version of this Manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

General Reminders

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

Section 2.2: Access+ and Trio HMO Plan Features

Changed the section name to include Trio HMO. ***Added*** language regarding the Trio+*Specialist* feature and other Trio HMO plan features.

Section 2.3: Blue Shield Accountable Care Organizations (ACOs)

Added a new section regarding the Virtual Primary Care Physician services through Accolade Care that is available to Trio HMO members. This new program includes benefits for ongoing primary care, mental health care, and Specialist care visits by phone or secure online video. Specialist care visits require a referral from their PCP.

Section 2.4: Blue Shield Added Advantage POS Plan

Claims Submission

Updated instructions for submitting POS/Self-Referral for Professional Claims and Institutional Claims.

Section 2.8: Benefits and Benefit Programs

Care Management

Updated section to indicate that the program is provided at no cost to our members.

Updated language to add the Blue Shield of California Behavioral Health Provider Network as a resource for members seeking maternity mental health providers.

Pharmaceutical Benefits

Drug Formulary

Updated section in boldface type and strikethrough, as follows:

For drugs that require prior authorization or an exception to benefit or coverage rules, coverage decisions are based on the medication coverage policies approved by Blue Shield's P&T Committee and the following will be considered during the review for coverage:

1. The requested drug, dose, and/or quantity are safe and medically necessary for the specified use.
2. Prior use of formulary alternative(s) or required ~~prescription~~ **step therapy** drugs have not achieved therapeutic goals (drug was discontinued due to lack of efficacy or effectiveness, diminished effect, sub-optimal results, or an adverse reaction) or are inappropriate for the specific member's situation.
3. Treatment is stable on the prescribed drug **and a change to an alternative treatment may cause clinical decompensation or immediate harm.**
4. Relevant clinical information provided with the authorization request supports the use of the requested medication over formulary drug alternatives **or required step therapy drugs.**

This includes:

a. Formulary **or step therapy** drug alternatives are expected to be ineffective or are likely or expected to cause an adverse reaction or physical or mental harm based on the characteristics of the member's known clinical characteristics and history of the member's prescription drug regimen.

b. Formulary **or step therapy** drug alternatives are not clinically appropriate because they are expected to do any of the following:

   i. Worsen a comorbid condition.

   ii. Decrease the capacity to perform daily activities.

   iii. Pose a significant barrier to adherence or compliance.

Drug Formulary - Commercial Plans

Added language in boldface type explaining prior authorization submissions:

Relevant clinical documentation that supports a prior authorization or step therapy exception review should be submitted with the request.

Once all required supporting information is received, a coverage decision, based upon medical necessity, is provided within the following timeline:

- Commercial plans within 24 hours for urgent requests and 72 hours for standard requests.

Mandatory Generic Drug Policy

Added language regarding exception request submissions, as follows:

Relevant clinical documentation that supports the use of the brand medication over the generic or biosimilar equivalent alternatives should be submitted with the exception request. Providers may request an exception by faxing the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form to (888) 697-8122. This form is available on www.blueshieldca.com/en/provider/authorizations/authorization-forms.

Mail Service Prescriptions changed to Home Delivery Services

Added language to note that home delivery prescriptions must be prescribed for a 90-day or 100-day supply, depending on plan benefits.

Pharmaceuticals in the Medical Benefit

Removed the following statement as this exclusion does not apply to medical benefits:

Further, a manufacturer's drug product may be excluded, or require medical necessity exception criteria, when the same or similar drug is available under Medical Benefits.

Office/Facility Administered Medications *changed to* Office Administered Medications

Added the following language:

In compliance with California Health and Safety Code Section 1375.8, Blue Shield no longer requires a health care service provider to assume or be at financial risk for any item described as a qualifying specialty pharmaceutical covered under the medical benefit. The health care provider is permitted to assume financial risk for these items after making the request in writing at the time of negotiating an initial contract or renewing a contract with Blue Shield.

The items included in California Health and Safety Code Section 1375.8 are:

- Injectable chemotherapeutic medications and adjunct injectable pharmaceutical therapies for side effects.
- Injectable medications or blood products used for the treatment of hemophilia, including Hemlibra.
- Injectable medications related to transplant services.
- Adult vaccines.
- Self-injectable medications.
- Other injectable medication or medication in an implantable dosage form costing more than $250 per dose.

Noted the following:

The Office Injectables are identified in the Richman Injectables List and are inclusive of high-cost drugs and specific childhood immunizations. This information can be found on Provider Connection at www.blueshieldca.com/en/provider/claims/policies-guidelines/medications.

Section 3.1: Enrollment and Eligibility

Member Primary Care Physician Selection, Assignment, and Change

Added language in the **Member Primary Care Physician Selection** section to indicate that Members 18 years of age and older, who are enrolled in a Trio HMO plan, and live in the service area may be eligible to select a virtual PCP with Accolade Care.

Added language pertaining to PCP selection for newborns, as follows:

If the mother of the newborn, or subscriber if the mother is not enrolled, has selected a virtual PCP with Accolade Care, the newborn will be assigned to an in-person PCP with a different IPA.

Section 4.1: Network Administration

Practitioner Credentialing

Added the following language to item #7 in boldface type below:

7. Have a current, unrestricted Drug Enforcement Agency (DEA) certificate. **Practitioners who are DEA eligible who do not have a DEA certification would be required to submit documentation of the practitioner's lack of DEA certificate and the name of a designated alternate prescriber.**

Specialist/Specialty Group Termination Notification Requirements

Updated language to remove accreditation regulatory standards as those use to determine termination notification requirements for Specialist/Specialty Groups. Blue Shield policies and state regulatory standards guide are used to determine requirements.

Provider Status Changes

Added the following language in the **Continuity of Care by a Terminated Provider** section:

The IPA/medical group is responsible for authorizing continuity of care services for their assigned members. Requests for continuity of care services should be submitted directly to the IPA/medical group.

Added language in the **Continuity of Care for Members by Non-Contracted Providers** section to clarify that a member whose provider is not part of an IPA/medical group can request continuity of care services by completing Blue Shield's Request for Continuity of Care Services form found on www.blueshieldca.com. Members who are assigned to an IPA/medical group should request continuity of care services from their IPA/medical group.

Compliance with Quality Improvement Programs

Added the following to the list of quality improvement activities:

- Submit medical records that include member ID, first and last name, gender, and date of birth. A member's name in the medical record must match the Blue Shield member ID name.
- Update member's immunization status in the California Immunization Registry (CAIR). The member's name on the CAIR needs to match the Blue Shield member ID name. CAIR release by parents for minors needs to be addressed during the 1st office visit.

Provider Directory

Added language to describe the way in which providers or members can report inaccurate Provider Directory information:

If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to Blue Shield for additional assistance in finding a provider. Providers, enrollees, potential enrollees, and the public can report inaccurate, incomplete, or misleading information with Blue Shield's Provider Directory by calling (800) 258-3089, by emailing providerdirectoryinaccuracies@blueshieldca.com, by filling out the "Report outdated information form" located on each provider results page on *Find a Doctor,* or by notifying the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI).

Language Assistance for Persons with Limited English Proficiency (LEP)

Blue Shield's Demographics and Language Services

Updated Blue Shield's Medicare threshold languages as follows:

- Contract H0504 all Plan Benefit Packages (PBPs): English & Spanish
- Contract H5928 all PBPs: English & Spanish
- Contract H2819 PBP 002 and 003: English & Spanish
- Contract H2819 PBP 001: English, Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Spanish, Tagalog, Vietnamese

Noted that for Medicare, CMS has "required" materials which are listed in CFR § 422.2267 *Required materials and content.* For Medicare Advantage plans, CMS sets the required threshold languages at 5%.

Cultural Awareness and Sensitivity (Diversity, Equity, and Inclusion) and Linguistic Resources and Training

Added the following paragraph about providers' requirement to complete training on advancing health equity:

Beginning January 2025, all contracted providers will be required to complete training on advancing health equity and will cover a variety of topics, including implicit bias, culturally and linguistically appropriate practices, diversity, equity, and inclusion, gender-affirming care, and more. This training will meet mandated requirements and will be reviewed annually to determine if there are any updated mandates. Once the training is finalized, a link to access the training will be provided to you.

Added the following new section to comply with AB 352:

Sensitive Health Information

Under California's existing Reproductive Privacy Act and the Confidentiality of Medical Information Act (CMIA), individuals have a fundamental right to privacy regarding their reproductive/medical decisions. Unauthorized disclosure of medical information is generally prohibited. California Assembly Bill 352 (AB 352) introduced significant changes to how Health Insurance Companies, Managed Health Care Organizations and their downstream/related entities are required to handle sensitive health information, including but not limited to reproductive health, abortion, and transgender services.

AB 352 expands the previously existing privacy requirements, specifying that on or before July 1, 2024, electronic health record (EHR) systems that store such information are required to adhere to additional provisions regarding medical information related to gender-affirming care, abortion and abortion-related services, and contraception ("sensitive services").

Specifically, EHR systems that collect and store data on behalf of providers and other organizations are required to:

- Ensure limited user access to all medical information, such that, specific medical information related to sensitive services is only accessible to the parties that are authorized to access that specific information.
- Prevent disclosure, access, transfer, transmission, or processing of sensitive services medical information to any person or entities outside of California.
- Segregate and differentiate any medical information related to sensitive services in a patient's record.
- Automatically disable access to any segregated medical information related to sensitive services by individuals and entities in any other state.

By law, Blue Shield of California/Blue Shield Life & Health insurance Company and providers must comply with these requirements. As such, Blue Shield expects that providers have systems and processes in place to address data sharing/disclosure requirements.

Section 4.4: Claims Administration

Performance – Regular and Complete Submission of Encounter Data

Updated the annual commercial membership benchmark to:

- 75% of existing members have an E&M visit annually

Updates made throughout the section to change the term "Provider Appeals and Dispute Resolution" to "Provider Dispute Resolution" and "appeal" to "dispute."

Provider Dispute Resolution

Unfair Billing and Payment Patterns

Levels

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

Blue Shield's Provider Dispute Resolution Process consists of two levels: Initial and Final.

CCR, Title 28, Section 1300.71.38 requires health plans to offer a provider dispute resolution process. State law does not require health plans to offer two levels of dispute.

How to submit a Provider Dispute

A provider dispute may be submitted online or by mail, for information on how to submit a dispute please visit Provider Connection at www.blueshieldca.com/en/provider/claims/disputes.

Final Provider Disputes

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

Provider or capitated entities that disagree with Blue Shield's written determination may pursue the matter further by initiating a final dispute.

Providers and capitated entities may submit a final dispute within 65 working days of Blue Shield's initial determination, or the time specified in the provider's contract, whichever is greater. For information on how to submit a final dispute, please visit Provider Connection at www.blueshieldca.com/en/provider/claims/disputes.

The final dispute must be submitted in accordance with the required information for a provider dispute.

Blue Shield will, within 45 working days of receipt, review the final dispute and respond in writing, stating the pertinent facts and explaining the reason(s) for the determination.

Provider Disputes of Medicare Advantage Claims

Updated section to direct providers to Provider Connection at www.blueshieldca.com/en/provider/claims/disputes to learn how to submit online or written disputes.

Non-Contracted Providers

Revised the appeal filing timeframe for $0 payments per CY 2025 Final Rule, as follows:

A provider has the right to request a reconsideration of payment denials within **65** calendar days for $0 payments.

Updated section to direct providers to Provider Connection at www.blueshieldca.com/en/provider/claims/disputes to learn how to submit online or written disputes.

UM Criteria and Guidelines

Added the following to the list of UM criteria to determine Mental Health and Substance Use Disorder medical appropriateness and coverage for fully insured products:

- Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder; Council on Autism Providers (CASP)
- Psychological and Neuropsychological Testing Billing and Coding Guide; American Psychological Association
- Clinical Guidelines for the Management of Adults with Major Depressive Disorder, Section 4. Neurostimulation Treatments; Canadian Network for Mood and Anxiety Treatments (CANMAT)

Updated language regarding medical necessity review for Mental Health and Substance Use Disorders (MH/SUD):

MH/SUD reviews are the responsibility of the Mental Health Service Administrator (MHSA). Behavioral Health medications are reviewed by Blue Shield.

Updated language regarding UM guidelines for Medicare members, as follows:

For Blue Shield Medicare HMO and PPO Members, Blue Shield follows Medicare national and local coverage guidelines and Blue Shield Medicare Part B Medication Policies. For Blue Shield Medicare PPO Plans, Part B Step Therapy requirements may also apply for select medications.

Blue Shield Medical and Medication Policies

Medical Policy

Removed "Evidence Street" from the list of sources that the Blue Shield Medical Policy Committee uses to review technologies for medical and behavioral health indications.

Medication Policy

Added language in boldface type as follows:

The Blue Shield Pharmacy and Therapeutics (P&T) Committee reviews pharmaceuticals. The P&T Committee bases clinical decisions on the strength of the available scientific evidence, consensus guidelines, and standards of practice, i**ncluding assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other relevant information as deemed appropriate including the clinical trial data submitted to the FDA to support a new drug, abbreviated new drug, or biologic license application (NDA, ANDA, BLA).**

Only **pharmaceuticals that have been FDA-approved** will be considered eligible for coverage, based on medical necessity.

Noted that Blue Shield Medical Policies can be found on Provider Connection at www.blueshieldca.com/en/provider/authorizations/policy-medical/list and Blue Shield Medication Policies at www.blueshieldca.com/en/provider/authorizations/policy-medications.

UM Authorization Reporting Process ("Authorization Logs")

Updated the data elements that are required on the Authorization log as well are the requirements for the submission of authorization logs, as follows:

- Approval/denial data files ("Authorization Logs") must be delivered via Provider Connection at www.blueshieldca.com/providerwebapp/authorization/IPAFileUpload using the IPA9 file format or via Secure File Transfer Protocol (SFTP) file to Blue Shield using the IPA10 file layout.
- If using the IPA9 file format, please adhere to the following requirements when submitting the file via the Provider Connection online portal: 1) The file must be in .xls or .xlsx format. 2) the filename must begin with IPA9. 3) The file should not be password protected. 4) The file should have a single worksheet.

Medical Benefit Drugs

Added language as follows:

Medical benefit drugs are typically covered under capitation, unless contracted differently. Certain exceptions to capitation include California Health and Safety Code Section 1375.8 medications that are listed below:

- Injectable chemotherapeutic medications and adjunct injectable pharmaceutical therapies for side effects.
- Injectable medications or blood products used for the treatment of hemophilia, including Hemlibra.
- Injectable medications related to transplant services.
- Adult vaccines.
- Self-injectable medications.
- Other injectable medication or medication in an implantable dosage form costing more than $250 per dose.

Mental Health and Substance Use Disorder Services

Added a new **Qualified Autism Service Professionals** section, which explains how the California Senate Bill 805 (SB 805) expanded the definition of qualified autism service professionals (QASP).

Blue Shield Responsibility

Updated the section below to indicate Blue Shield's responsibility in mental health and substance use disorder services:

Blue Shield remains responsible, unless otherwise indicated by the provider agreement, for the services below even when the member's mental health and substance use disorder benefits are being managed by Blue Shield's MHSA.

- Out-of-service area requests.
- Behavioral Health specialty medications per www.blueshieldca.com/en/provider/claims/policies-guidelines/medications

For contract exceptions, the group may work with Network Management as needed.

Organ and Bone Marrow Transplants

Added clarifying language below:

The IPA/medical group is responsible for medical necessity review of and authorization for the following transplants:

- Corneal
- Kidney only
- Skin

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.

Services to obtaining the transplanted material from a living donor or an organ transplant bank will be covered.

Prior Authorization

Added the following to list of items requiring prior authorization (except for emergency services):

1. MH/SUD Residential Treatment Center
2. MH/SUD Partial Hospital Program
3. MH/SUD Intensive Outpatient
4. Transcranial Magnetic Stimulation (TMS)
5. Gender Affirming Care
6. Electroconvulsive Therapy (ECT)
7. Applied Behavior Analysis (ABA)
8. Neuropsychological Testing

Added language to indicate that for services NOT delegated to the IPA/medical group, requests for MH/SUD services should be made directly through the MHSA.

Section 5.2: Quality Management Programs

Delegation of Credentialing

Credentialing Oversight

Updated reporting requirements for audits in boldface type below:

The IPA/medical group will be required to submit **all requested audit documentation, including** a complete credentialing roster **prior to the scheduled audit date. The roster must include name, degree, role,** specialty, **board certification information, initial** credentialing and **current** recredentialing dates, **credentialing status (Cred/Recred), NPI number and license** number at least two (2) weeks prior to the scheduled audit date.

Removed the **Peer Review Process** section.

Added 3rd and 4th quarter reporting requirements for credentialing reports.

Added the following new section addressing abortion provider protections under SB 487:

Abortion Provider Protections

Senate Bill 487 (SB 487) requires IPA/medical groups establish a written policy and procedure describing that the organization is prohibited from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California.

Service Accessibility Standards

Behavioral Health Appointment Access Standards

Updated cells displaying behavioral health access standards.

Provider Availability Standards for Commercial Products

Geographic Distribution

Updated cells displaying provider accessibility measures.

Provider-to-Member Ratio

Added chart detailing standard ratios of number of practitioners to members.

Linguistic and Cultural Requirements

Updated cells displaying provider linguistic and cultural standards.

Additional Measurements for Multidimensional Analysis for Commercial Products

Updated compliance target from 85% to 70% for Open PCP Panels, within the associated chart which displays measures regarding Commercial products.

Additional Measurements for Multidimensional Analysis for Medicare Advantage Products

Updated compliance target from 85% to 70% for Open PCP Panels, within the associated chart which displays measures regarding Medicare Advantage products.

Section 6.1: Blue Shield Medicare Advantage Plan Program Overview

Blue Shield Medicare Advantage HMO and HMO D-SNP Plan Service Areas

Updated language to indicate that this section applies to both Medicare Advantage HMO and HMO D-SNP plans.

Section 6.2: Blue Shield Medicare Advantage Plan Benefits and Exclusions

Medication Therapy Management Program (MTMP)

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

Blue Shield provides a Medication Therapy Management Program (MTMP) for its Medicare Part D members to assist them in managing their chronic conditions. The Blue Shield MTMP is for members meeting all of the following criteria:

- Have three of the following conditions:
  - Alzheimer's Disease
  - Bone diseases – arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Dyslipidemia
  - End-stage renal disease (ESRD)
  - Human immunodeficiency virus/Acquired immunodeficiency syndrome (HIV/AIDS)
  - Hypertension
  - Mental Health (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions)
  - Respiratory Disease (including asthma, chronic obstructive pulmonary disease (COPD), and other chronic lung disorders
- Receive eight or more different covered Part D maintenance medications monthly
- Likely to incur an annual cost threshold established by CMS each calendar year for Medicare covered prescriptions

Section 6.3: Blue Shield Medicare Advantage Plan Enrollment and Eligibility

Enrollment Periods

Updated the **Initial Coverage Election Period (ICEP)** section to include the following:

- For individuals who cannot use their ICEP during their Initial Enrollment Period (IEP), the individual would have 2 months after the month in which they are first entitled to Part A and enrolled in Part B to use their ICEP.

Effective Date of Coverage

Removed language stating that beneficiaries cannot request their enrollment effective date and ***replaced*** it with the following, to comply with CMS-4205-F:

If the MA organization or Part D plan sponsor receives an enrollment or disenrollment request, determines the beneficiary is eligible for more than one election period and the election periods allow for more than one effective date, the MA organization or Part D plan sponsor must allow the beneficiary to choose the election period that results in the desired effective date.

Section 6.5: Blue Shield Medicare Advantage Plan Medical Care Solutions

Health Risk Assessment (HRA)

Updated language indicating that Blue Shield will contact newly enrolled Medicare Advantage Plan members telephonically or by mail to complete an HRA. For D-SNP members, the HRA survey is mailed to the member and Blue Shield support staff follow up with telephonic outreach to the member to complete the HRA over the phone.

Individualized Care Plan and Interdisciplinary Care Team for Dual Eligible Special Needs Plan (D-SNP) Members

Updated language in boldface type below:

The ICP is shared with the member or member's caregiver, the member's PCP, **the member's active specialists,** and the medical group. **A preventative health ICP is created for members who do not complete the HRA.**

Added the following language:

Blue Shield completes an Interdisciplinary Care Team (ICT) meeting at enrollment and annually thereafter. The ICT meeting is a collaboration to discuss the member's health care needs and to assist the member with coordination of services. The ICT is composed of the member and/or member caregiver (when they agree to participate), the Blue Shield RN Care Manager, the Blue Shield Social Worker, the Blue Shield Medical Director, the Blue Shield Pharmacist, and the member's PCP and/or active specialists (when they agree to participate).

Second Opinions

Added language describing who obtains, reviews, and processes Medicare Advantage second opinions, as follows:

The IPA/medical group is responsible for obtaining a second opinion outside the IPA/medical group network if an appropriately qualified licensed health care professional is not available in the IPA/medical group network.

Second opinions are reviewed and processed by the IPA/medical group.

Medicare Advantage Plan Reporting Requirements

Updated methods for submitting reports to Blue Shield and ***added*** reporting requirements for the following reports:

- Part C Report (Organization Determination)
- Quarterly Denial File Review Submission
- ODAG Report

Section 6.6: Blue Shield Medicare Advantage Plan Member Rights and Responsibilities

Updated Member Rights and Responsibilities language to align with current *Evidence of Coverage* documents.

Key Terms and Definitions

Clean Claim – Medicare Advantage

Added the following language, which further defines "clean claims," as it lays out provider responsibilities regarding clean claims:

A "clean" claim is one that does not require the payer to develop external to their Medicare operation on a prepayment basis. Clean claims must be filed in the timely filing period. A clean claim has all basic information necessary to adjudicate the claim, and all required supporting documentation.

Delegated Entity/Specialty Health Plan

Updated the Delegated Entity definition to include Specialty Health plan, as follows:

For a Blue Shield Contracted Delegated Entity that is a Limited/Restricted Knox Keene or Specialty Health Plan, that has contractually sub-delegated any functions, they must demonstrate their annual oversight and monitoring process. Audit preparation would include submission of policies and procedures along with audit results and any supporting documentation and CAPs.

Monitoring Oversight

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

Federal and state regulations specifically require oversight of compliance of Delegated and Sub Delegated Entities. Oversight of the Delegated Entity for compliance ensures that Blue Shield is compliant with federal and state requirements. Blue Shield in partnership with the Delegated Entity performs the required oversight of designated operational areas to detect deficiencies early and implement corrective actions.

Provider Dispute Resolution (PDR) Process - Commercial

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

A provider's written notice challenging, appealing, or requesting reconsideration of a claim (or a bundled group of similar multiple claims that are individually numbered) that has been denied, adjusted, contested, or seeking resolution of a billing determination or other contract disputes or disputing a request for reimbursement of an overpayment of a claim.

Provider Dispute Resolution (PDR) Process - Medicare Advantage

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

A formal process for receiving, resolving, and reporting provider disputes for Medicare Advantage claims., including decisions where a non-contracted provider contends that the amount paid by the payer for a covered service is less than the amount that would have been paid under Original Medicare.

Measuring Timeliness and Accuracy

Fee Schedule Accuracy – Medicare Advantage

Added the following to items that Blue Shield will accept to determine accuracy on non-contracted 30-day claims based on the location of where the services were rendered:

(4) Merit Based Incentive Payment System (MIPS) payment adjustments are applied on a claim-by-claim basis, to payments made for covered professional services furnished by a MIPS eligible clinician. CMS assigns a maximum + & - MIPS adjustments payment percentage to every year. The MIPS Payment Adjustment Data File for Delegated Entities is located on the Delegation Claims Oversight Share Point site. Reach out to your assigned auditor if access is needed.

Commercial Evidence of Payment (EOP)/Remittance Advice (RA)

Added the following address where appeals should be submitted should providers not agree with the resolution of a claims dispute:

Blue Shield of California Provider Dispute Resolution Office
P.O. Box 272620
Chico, CA 95927-2620

Best Practices and Claims Adjudication

Added new section for Emergency Claims, as follows:

Emergency Claims

The Emergency Medical Treatment and Labor Act (EMTALA) is an accepted standard in the health care industry that applies to emergency medical care. The EMTALA provides protection to consumers from high medical costs that may arise from emergency situations and requires insurance companies to provide coverage for emergency care based on symptoms, not the final diagnosis. This is speaking to payment of a claim versus denial.

Care for issues that may be chronic or blatantly non-emergent generally do not fall into qualifying for immediate treatment under the prudent layperson standard and would generally be considered as non-emergent conditions. These can be such cases as:

- Normal follow-up of a medical condition.
- Removal of stitches.
- Medication refills.

"***Prudent Layperson***" is described as:

- A person who is without medical training and who draws on their practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought.
- A person with an average knowledge of health and medicine.

The California Department of Managed Health Care (DMHC) provided guidance regarding when emergency services provided to an enrollee must be reimbursed as per the Knox-Keene Act Standard lastly in APL 17-017 which cited:

- Health and Safety Code § 1371.4 (b): A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.
- Health and Safety Code § 1371.4 (c): Payment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.
- Health and Safety Code § 1317.1 (b): An Emergency Medical Condition which is defined as a medical or mental health condition (and/or substance use disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
    - Placing the patient's health in serious jeopardy.
    - Serious impairment to bodily functions.
    - Serious dysfunction of any bodily organ or part.

    Examples of such conditions could be but are not limited to:

    - Loss of consciousness
    - Seizure
    - Chest pain
    - Trouble Breathing
    - Choking
    - Severe pain
    - Suicidal ideations
    - Overdose

The standard articulated by the Knox-Keene Act in Section 1371.4 and 1371.5 turns on whether the enrollee him/herself reasonably believed he/she had an emergency medical condition. This standard is not the objective "reasonable person" or "prudent layperson" standard that asks whether a reasonable person would have believed a medical emergency existed. Rather, the Knox-Keene Act's standard is subjective and takes into consideration whether the enrollee's belief was reasonable given the enrollee's age, personality, education, background, and other similar factors.

Please note that whether the enrollee believed he/she was experiencing a medical emergency may not always be evident from the medical record of the visit because the records may not capture the mindset of the patient when he/she presented at the emergency room.

Added new section for Senate Bill 855 regulations, as follows:

SB 855

SB 855 requires plans, for level of care determinations, to use treatment criteria developed by the non-profit, clinical professional association of the relevant clinical specialty. This is spelled out in Health and Safety Code Section 1374.721 (b) which states:

Effective January 1, 2021, in conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, pursuant to this section, plans must apply criteria and guidelines set forth in the "most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty."

These associations are listed on Attachment A of APL 21-002 dated January 5, 2021.

- Substance Abuse Disorder, any age – American Society of Addiction Medicine (ASAM).
- Mental Health Disorders, patients 18 and over – American Association of Community Psychiatrists.
- Mental Health Disorders, patients 6 to 17 years of age - American Association of Community Psychiatrists OR American Academy of Child & Adolescent Psychiatry.
- Mental Health Disorders, patients 0 to 5 years of age - American Academy of Child & Adolescent Psychiatry.
- Gender Dysphoria – World Professional Association for Transgender Health (WPATH).

Appendix 4-B. Qualifying Medical Benefit Drug Claims Submission Instructions

Updated block 24 D to include JW (waste indicator) and JZ (no waste indicator) modifiers.

Appendix 4-C: Actuarial Cost Model

Updated the model with 2025 data.

Appendix 5-A: Utilization Management Delegation Standards

Updated the **Required Reporting to Health Plan – Commercial Standards Table** methods for submitting reports to Blue Shield and ***added*** reporting requirements for the following:

- Commercial Turnaround Time Report
- Quarterly Denial File Review Submission

Appendix 5-B: Credentialing/Recredentialing Standards

III. Credentialing/Appointment Process

Updated to the submission address where data elements should be emailed to as follows: IPADatainformation@blueshieldca.com

IV. Organizational Provider Credentialing

Added the following to this section:

D. Medicare/CMS Institutional Providers and Suppliers, such as Hospices, Clinical Laboratory, Comprehensive Outpatient Rehabilitation Facilities (CORF), Outpatient Physical Therapy (PT) Providers, Speech Pathology Providers, End Stage Renal Disease Providers (ESRD), Outpatient Diabetes Self-Management Training Providers, Portable X-Ray Suppliers, Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC).

G. Assess Medicare/CMS Institutional Providers and Suppliers Providers against requirements prior to contracting and at least every three (3) years.

Added a new section **X. Senate Bill 487 Abortion Provider Protections.** See Section 5.2 Abortion Provider Protections above for language.