601 12th Street
Oakland, CA 94607

October 16, 2024

Subject: **Notification of January 2025 Updates to the Blue Shield *Hospital and Facility Guidelines***

Dear Provider:

Blue Shield is revising the *Hospital and Facility Guidelines.* 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 *Hospital and Facility Guidelines Manual* (Manual) 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 included by reference in the agreement between Blue Shield of California (Blue Shield) and the hospitals and other facilities contracted with Blue Shield. If a conflict arises between the *Hospital and Facility Guidelines* 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 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: Hospital and Facility Responsibilities

Quality Management and Improvement

Patient Safety

Added the following bullet point to list of activities supporting and improving patient safety:

We take an active role in supporting and improving patient safety through a variety of activities including:

- Ongoing assessment and evaluation of hospital safety, utilization, patient experience, and quality performance. To include, but not limited to, quarterly performance reviews, implementation of action and improvement plans, and technical assistance for specific hospital quality domains.

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) bill 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.

Provider Availability Standards for Commercial Products

Geographic Distribution

Updated numerous cells in chart which displays accessibility standards for different providers.

Provider-to-Member Ratio

Updated numerous cells in chart which displays providers, product type and compliance standards.

Provider Availability Standards for Medicare Advantage Products

Linguistic and Cultural Requirements

Updated cells in chart which displays providers and standards related to language access.

Additional Measurements for Multidimensional Analysis for Commercial Products

Updated the chart "FREQUENCY" cell for Open PCP Panel from Quarterly to Annually.

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.

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 PBPs: English & Spanish
- Contract H5928 all PBPs: English & Spanish
- Contract H4937 PBP 001: English, Spanish & Chinese
- Contract H4937 PBP 002: 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, Sensitivity (Diversity, Equity, and Inclusion), and Linguistic Resources and Training

Added the following paragraph explaining the requirement for providers to complete training on advancing health equity, in accordance with SB 923:

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.

Facility 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).

Section 3: Medical Care Solutions

UM Criteria and Guidelines

Deleted and ***replaced*** this section to include resources that Blue Shield and Blue Shield Life use to determine medical appropriateness and coverage.

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

Deleted and ***replaced*** the following language concerning how the Blue Shield Pharmacy and Therapeutics (P&T) Committee makes clinical decisions:

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, including 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).

Updated item b, in list of principles of evidence-based medicine, to the following:

b. In addition to randomized controlled trials, medical society guidelines, and accepted community standard of practice will be considered.

Updated the following sentence concerning pharmaceuticals eligible for coverage, boldface type and strike-through:

Only **pharmaceuticals that have been FDA-approved** ~~when sufficient credible evidence (such as clinical studies and trials, peer review scientific data, journal literature) has demonstrated safety and efficacy, will a technology or pharmaceutical~~ be considered eligible for coverage, based on medical necessity.

Deleted **language** in strike through from the following paragraph:

Additional authorization for select medical drugs may also be required for the administration of the drug at an outpatient hospital facility site in addition to authorization of coverage for the drug. ~~Further, a manufacturer's drug product may be excluded, or require medical necessity exception criteria, when the same or similar drug is available.~~ Step therapy may also apply requiring the use of preferred agents including generic or biosimilar drugs. Refer to the medication policy. For Blue Shield Medicare Advantage HMO Members, Blue Shield follows Medicare guidelines for risk allocation, Medicare national and local coverage guidelines. For Blue Shield Medicare PPO Plans, Blue Shield Medication Policies and Step Therapy requirements may also apply for select medications.

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.

Admission Authorization

Discharge Planning

Added new section discussing the Blue Shield Medical Care Solutions team collaboration to coordinate discharges to the next level of care.

The Blue Shield Medical Care Solutions team is committed to ensuring our members receive services at the appropriate level of care. Our concurrent review team will collaborate with facilities to coordinate discharges to the next level of care. This collaboration will begin upon admission, with the concurrent review team engaging facility staff to understand the member's needs upon discharge.

The Blue Shield Medical Care Solutions will reach out to the facility to plan authorizations for next level of care, placement to available in-network providers, and/or any durable medical equipment necessary. For complex cases, our internal teams in utilization management and case management will collaborate by phone or, if needed, interdisciplinary meetings with facility resources and plan staff in attendance.

Prior Authorization List for Network Providers

Updated the Mental Health and Substance Use Disorder services within the "Provider Authorization List for Network Providers" chart.

Continuity of Care for Members by Non-Contracted Providers

Added the following paragraph, which explains duty to provide members continuity of care:

"*Continuity of Care Services*" are those Covered Services that a qualifying member is entitled to receive pursuant to California Health and Safety Code Section 1373.96, Completion of Covered Services, and Public Health Service Act, Title XXVII, part D, Sections 2799A-3 and 2799B–8, Continuity of Care (hereinafter Consolidated Appropriations Act, 2021 (CAA), Section 113).

Added language about providers' requirement to provide continuity of care after termination, as follows:

Following termination, providers agree to continue rendering provider services that are Continuity of Care Services to members who qualify for completion of Continuity of Care Services as determined by Blue Shield at the rates and under terms set forth in the provider's agreement. For members who retain eligibility under the plan contract through which they are enrolled and who are receiving covered services from a provider at the time of termination, the provider shall continue to provide covered services until such covered services are completed or until Blue Shield makes reasonable and medically appropriate provision for the assumption of such Covered Services by another provider. The provider shall be compensated for such covered services in accordance with the provider's agreement with Blue Shield. Blue Shield shall make reasonable efforts to timely notify such members that a provider is no longer a contracting provider and, for members in HMO plans, shall make reasonable and timely efforts to effectuate the assumption of covered services by another provider.

Section 4: Billing and Payment

Changed email address for information on electronic submissions, from EDI_BSC@blueshieldca.com to TPO@blueshieldca.com, throughout entire section.

Changed "Appeals and Dispute" to "Dispute," throughout entire section.

Claims Submission

Completing the UB 04 Form - Paper Submission

Deleted language about Blue Shield utilizing the Optical Character Recognition (OCR) to scan paper claims.

Updated bullet point in list of items to facilitate the efficient and accurate claims processing of paper forms, in boldface type below:

- No narrative descriptions of procedure, modifier or diagnosis are on the claim. The CPT, Modifier, ICD-10-CM, or ICD-10-PCS codes are sufficient. For drug codes, the CPT, NDC, **Modifiers JW (indicator single dose container drug waste) and JZ (indicator no single dose container drug waste)** are required.

Removed the **UB-04 Form Locators** section as this language is included in Appendix 4-F UB - 04 General Instructions.

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.

Section 5: Blue Shield Benefit Plans and Programs

Blue Shield HMO Plans

Access+ *Specialist*℠ and Trio+ *Specialist* Feature

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

Medicare Part D

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

Members meeting these criteria will be automatically enrolled in the MTMP at no additional cost relating to the program and they may opt-out if they desire.

Blue Shield PPO Plans

Added list of PPO plans that Blue Shield offers.

Blue Shield Medicare Advantage PPO Plans

Added list of Medicare Advantage PPO plans that Blue Shield offers.

Federal Employee Program (FEP)

Required Prior Authorization

Updated numerous cells within a chart displaying which services require prior authorization.

Integrated Care Management Program for FEP

Added the following conditions to the list of conditions Blue Shield provides disease management services for:

In 2025 Blue Shield will add the following list of Rare Disease Management to the current list of diagnosis above. Amyotrophic Lateral Sclerosis, Crohn's Disease, Cystic Fibrosis- adult and pediatric, Hemophilia, Systemic Lupus Erythematosus, Multiple Sclerosis, Myasthenia Gravis, Myositis, Parkinson's Disease, Rheumatoid Arthritis, Scleroderma, Seizure Disorders, Sickle Cell Disease adult and pediatric.

Care Management

Maternity Management

Updated 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.

Section 6: Capitated Hospital Requirements

Capitated Services Claims Processing

Removed sections concerning Third-Party Organization, Claims Compliance and Monitoring, Prepayment Claim Review, and Billing for Copayments.

Appendices

Appendix 4-E List of Office-Based Ambulatory Procedures

Added the following CPT codes:

31242	Nasal/sinus ndsc dstrj ablation
31243	Nasal/sinus ndsc dstrj cryoablation
52284	Cysto w/dilat rx balo cath
58580	Trnscervical abltn uterine fibroid
64596	Insj/rplcmt perq eltrd rap n w/nstim

Removed the following procedure codes:

0465T	Supchrdl njx rx w/o supply

Appendix 4-F UB-04 General Instructions

Added language that if the following data elements are not provided, Blue Shield will consider the claim unclean and return for correction:

FL05 Federal Tax ID

FL42 Revenue Codes

FL46 Service Units

FL67a-q Other Diagnosis and POA Indicator

Appendix 5-A The BlueCard® Program

Types of Medicare Advantage Plans

Deleted and ***replaced*** the MA PPO shared networks language and chart to reflect that MA PPO shared networks are available in 48 states and two territories.

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

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.

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).

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