601 12th Street
Oakland, CA 94607

October 16, 2024

Subject: **Notification of January 2025 Updates to the Blue Shield *Independent Physician and Provider Manual***

Dear Provider:

Blue Shield is revising the *Independent Physician and Provider Manual* (Manual). The changes in each provider manual section listed below are effective 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 *Independent Physician and Provider Manual* be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *Independent Physician and Provider Manual* is included by reference in the agreement between Blue Shield of California (Blue Shield) and those physicians and other healthcare professionals who are contracted with Blue Shield. If a conflict arises between the *Independent Physician and Provider Manual* and the agreement held by the individual and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the January 2025 version of this Manual, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091.

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: Provider Responsibilities

Provider Certification

Reporting Provider Status Changes

Updated language explaining the timeline for providers to notify Blue Shield of demographic or administrative changes, in boldface type below:

Demographic/Administrative Changes

The provider or medical group must notify Blue Shield of demographic or administrative changes **at least 90 calendar days prior to the change or** as soon as possible for timely directory updates **unless your Blue Shield provider agreement states otherwise**. Examples of these types of demographic or administrative changes include **roster changes/terminations**, panel status, office location, office hours, office email, telephone numbers, fax numbers, billing address, tax identification number, board status, key contact person, etc.

Credentialing Status Changes

Updated language explaining the timeline for providers to notify Blue Shield of credentialing status changes in boldface type below:

Providers also are required to notify Blue Shield Provider Information & Enrollment **within 30 calendar days** whenever there are changes in their individually licensed provider's credentials status (i.e., license status, state probation, liability carrier, accusation, etc.), as well as changes in their practice location and demographic information.

Provider Directory

Added language describing the ways 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).

Credentialing and Recredentialing

Added language to item #5 in boldface type below:

5. 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.**

Medical Record Review

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.

Service Accessibility Standards

Behavioral Health Appointment Access Standards

Updated the chart displaying Behavioral Health Appointment Access Standards, in boldface type below:

ACCESS-TO-CARE	STANDARD
Initial routine visits with non-physician practitioners, **substance use disorder providers,** and behavioral health physicians	Within 10 business days
Routine and follow-up visits with non-physician practitioners **and substance use disorder providers**	Within 10 business days

Provider Availability Standards for Commercial Products

Geographic Distribution

Updated numerous cells, within Geographic Distribution chart, which displays provider accessibility measures.

Provider-to-Member Ratio

Updated numerous cells, within Provider-to-Member Ratio chart, which displays provider accessibility measures.

Linguistic and Cultural Requirement

Updated numerous cells, within the Linguistic and Cultural Requirement chart, which displays provider linguistic and cultural standards.

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)

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%.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

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, 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.

Section 3: Medical Care Solutions

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)

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.

Medication Policy *(cont'd.)*

Updated language concerning pharmaceuticals eligible for coverage, in boldface type and strike-through below:

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.

Use of Out of Network Health Care Professionals and Facilities

Updated the process for requesting an out of network exception, as follows:

Providers requesting an exception for services rendered by an out of network health care professional or facility must call Blue Shield at (800) 541-6652 to request the *Out of Network Exception Request Form.* Requests for an exception must be made by a provider prior to services being rendered. When a request is approved for an out of network health care professional or facility for non-emergent services, the member is covered at their in-network benefit level and the provider will be required to execute a letter of agreement.

Continuity of Care for Members by Non-Contracted Providers

Added the following definition for 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).

Continuity of Care for Members by Non-Contracted Providers *(cont'd.)*

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.

Prior Authorization List for Network Providers

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

Drug Formulary

Added language in boldface type below:

Blue Shield of California Pharmacy and Therapeutics (P&T) Committee r**eviews FDA-approved medications for inclusion on the formulary** and **development of** medication coverage policies and clinical coverage requirements based on the medical evidence for comparative safety, efficacy, and cost when safety and efficacy are similar.

Updated items in a list of criteria upon which coverage decisions are made in boldface type below:

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

4. Relevant clinical **documentation** provided with the authorization request supports the use of the requested medication over formulary **or required step therapy** drug alternatives.

    a. **Formulary or step therapy drugs 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 *(cont'd.)*

Added the following sentence to the paragraph explaining how providers have the alternate option to use AuthAccel to process authorizations:

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

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.

Section 4: Billing

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 Processing

Paper Claim Forms (Using the CMS 1500 Claim Form)

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

Claims Review Monitoring Program

Provider on Review

Updated the following bullet point in list of billing irregularities that may result in prepayment review, in boldface type below:

- Failure to include NDC, CPT, **and Modifiers JW or JZ** for drugs.

Provider Payment

Blue Shield Provider Allowances

Updated the following bullet points in list of methods by which allowances are determined, in boldface type and strike-through:

- Immunization allowances are AWP-based**, unless specified as ASP.**
- For drugs, CPT~~,~~ or HCPCS ~~and~~ NDC**, and Modifiers JW (indicator single dose container drug waste) and JZ (indicator no single dose container drug waste)** are required for payment regardless of reimbursement methodology.

Special Billing Situations

Office-Administered Injectable Medications

Updated language regarding the "Drop Ship" program. For program details, please visit Provider Connection at www.blueshieldca.com/provider.

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.

Blue Shield HMO Plans

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

Updated 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*** 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)

Mental Health and Substance Use Disorder Services for FEP

Updated the following bullet describing requesting assistance, in strike-through:

- For any services that are to be rendered in a residential treatment center (RTC), please call (800) 995-2800 before services are rendered. Services in an RTC are a covered benefit, when medically necessary, for members who are enrolled ~~and actively participating in the integrated care management program at Blue Shield.~~ A case manager will be able to assist you and the member to develop a plan that meets the member's needs.

Required Prior Authorization

Updated numerous cells in the "Required Prior Authorization" chart, which contains information about services that require prior approval, and any additional information required.

Integrated Care Management Program for FEP

Added the following 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.

Mental Health and Substance Use Disorder Services

Updated with language describing the different mental health and substance use disorder services networks as they apply to fully-insured and self-funded and shared advantage products, as follows:

Blue Shield's mental health service administrator (MHSA) for commercial fully-insured HMO and PPO products is Human Affairs International of California (HAI-CA). Blue Shield manages mental health and substance use disorder services for self-funded and shared advantage products.

Members covered under fully-insured products must utilize the Blue Shield MHSA provider network to access mental health and substance use disorder covered services. Blue Shield of California's network of contracted mental health and substance use disorder providers is utilized for members covered under self-funded and shared advantage products. Prior authorization must be obtained for services listed under the section Blue Shield Covered Services for Commercial Plan Members below.

Mental health and substance use disorder office visits **do not** require prior authorization.

Members covered under fully-insured products should use the Member Self-Referral phone number (877) 263-9952 to contact Blue Shield's MHSA to access behavioral health care.

Members covered under self-funded and shared advantage products should contact Blue Shield of California's Customer Service department at (800) 873-3605 to access behavioral health care.

Telebehavioral Health Online Appointments

Updated language about virtual online appointments in boldface type below:

The Blue Shield offers real-time, two-way communication via online virtual appointments with a mental health or substance use disorder provider. Appointments are available for counseling services, psychotherapy, and medication management with participating therapists and psychiatrists. To access Telebehavioral health providers, **Commercial fully-insured members** can visit Find a Doctor on blueshieldca.com. Once on Find a Doctor, click on Mental Health to be directed to Blue Shield's MHSA website. **Click on *Provider Search Telebehavioral* tab on the left of the screen.** Enter the required search criteria, hit search **and a list of telebehavioral health providers that match your criteria will appear. Depending upon the provider selected there may be an opportunity to access the provider's website to schedule the appointment online. Self-Funded and Shared Advantage members should reach out to the Mental Health Customer Service number on the back of their ID card.**

Qualified Autism Service Professionals (QASP)

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

Effective January 1, 2024, California Senate Bill 805 (SB 805) expanded the definition of qualified autism service professionals (QASP) to include psychological associates, associate marriage and family therapists, associate clinical social workers, and associate professional clinical counselors. The bill also requires that those who qualify as a QASP meet the training and experience criteria established by the California Department of Developmental Services by July 1, 2026.

In accordance with the law, Blue Shield encourages all participating network providers to comply with the changes made via SB 805 to Health & Safety Code Section 1374.73 and Insurance Code Section 10144.51.

Blue Shield MHSA Covered Services for Commercial Fully-Insured Plan Members

Updated language explaining practice guidelines for covered services in boldface type below:

The Blue Shield MHSA will utilize ASAM, LOCUS, CALOCUS, ECSII, **Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder, Psychological and Neuropsychological Testing Billing and Coding Guide, and Clinical Guidelines for the Management of Adults with Major Depressive Disorder** for mental health and substance use disorder reviews for commercial **fully-insured** members. Additional mental health and substance use disorder guidelines may be added as they become available from non-profit professional associations in accordance with California law.

***Note*: The Blue Shield MHSA manages Applied Behavior Analysis (ABA) for Commercial Fully-Insured, Self-Funded and Shared Advantage members.**

Mental Health and Substance Use Disorder Services for Self-Funded Accounts (ASO), Shared Advantage Products, and the Federal Employee Program (FEP) (PPO)

Added the following note concerning Self-Funded (ASO), Shared Advantage Products:

Note: Applied Behavior Analysis (ABA) services for Self-Funded (ASO) and Shared Advantage Products are managed by the Blue Shield MHSA and should be accessed through the MHSA network of contracted providers.

Added the following new section:

Blue Shield Covered Services for Self-Funded and Shared Advantage Plan Members

The Blue Shield will utilize MCG guidelines and Medical Policy for mental health and substance use disorder reviews for commercial self-funded and shared advantage plan members.

Blue Shield is responsible for prior authorization for the following services:

- Non-emergency mental health or substance use disorder Hospital inpatient admissions, including acute and residential care
- Outpatient Mental Health and Substance Use Disorder Services listed below when provided by a Blue Shield contracted provider, as required by the applicable plans *Evidence of Coverage* or *Health Service Agreement.*
    - Electro-convulsive Therapy (ECT) and associated anesthesia.
    - Intensive Outpatient Program (IOP).
    - Partial Hospitalization Program (PHP).
    - Neuropsychological Testing should be considered for coverage through the patient's mental health benefit when:

      After completion of a comprehensive Behavioral Health evaluation and neurological evaluation, if the Behavioral Health provider or neurologist determines the neuropsychological testing is required, the provider will request authorization and coordinate the request,
    - Transcranial Magnetic Stimulation (TMS).
    - Non-emergency inter-facility transports.

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.

Added the words "or Trio" to the product name "Access+ **or Trio+***Specialist*," throughout the section.

Provider Status Changes

Specialist/Specialty Group Termination Notification Requirements

Updated language to remove accreditation regulatory standards as those used to determine termination notification requirements for Specialist/Specialty Groups and added language in boldface type below:

Blue Shield recognizes the importance of timely member notification prior to the termination of a regularly seen specialist or specialty group. In accordance with **state regulatory standards and Blue Shield Policies,** Blue Shield members are required to receive at least **60** days prior notice of an upcoming physician termination, including specialist or specialty group termination. **Federal law, however, requires that members be notified at the time of the provider's contract termination or the employer group's termination of its Blue Shield contract.**

Therefore, to comply with all notification requirements, members must receive notices both 60 days prior to the specialist termination and again at the time of termination on a timely basis.

Appendices

Appendix 4-A Special Billing Guidelines and Procedures

Ambulance Claims

Added the following note about non-emergency services:

Non-Emergency Ambulance services should have pre-authorization completed prior to services being rendered.

Updated the chart for coding requirements from the ambulance claim guidelines.

HEDIS® Guidelines

Updated HEDIS Guidelines chart **Comprehensive Diabetes Care**, by removing CPT Category II Code 3072F.

Appendix 4-C CMS 1500 General Instructions

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

21	Diagnosis or Nature of Illness or Injury
24a	Date(s) of Service
24d	Procedure, Services, or Supplies
24g	Days or Units
25	Federal Tax ID Number

Appendix 4-F List of Office-Based Ambulatory Procedures

Added the following procedure 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 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.

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