Medi-Cal Provider Manual

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SECTION 1: INTRODUCTION

Welcome

Thank you for being a Blue Shield of California Promise Health Plan network provider. As a network provider, you play a very important role in the delivery of healthcare services to our members.

The Blue Shield Promise Health Plan Medi-Cal Provider Manual is intended for network providers of Blue Shield Promise Medi-Cal Plans. It is to be used for the provision of covered services to Blue Shield Promise Health Plan Members. This manual contains policies, procedures, and general reference information including minimum standards of care that are required of Blue Shield Promise Health Plan providers. Specific information on benefits, eligibility, enrollment, and co-payments are outlined within this manual.

We hope this information will help you better understand our operations. Should you or a staff member have questions about information contained in this manual or need additional information about Blue Shield Promise Health Plan, please feel free to contact our Provider Services Department or your Provider Relations Representative.

We look forward to working with you and your staff to provide quality managed-healthcare service to Blue Shield Promise Health Plan members.

Blue Shield of California Promise Health Plan

Blue Shield Promise Health Plan acts as a "gatekeeper" for its member's healthcare needs, providing managed health care services to our members. Blue Shield Promise Health Plan is responsible for monitoring the coordination and delivery of the health care our Members receive through follow-up care, pre-authorization approval of referred services, ordering of therapy, consultation, pharmaceutical services, and admission to hospitals.

Medi-Cal

Medi-Cal in California (known as Medicaid in other states) is administered by the Department of Health Care Services (DHCS). It was established in 1965 to provide the necessary medical services for those eligible individuals whose income and resources were insufficient to provide for their health care. In California, the Medi-Cal program falls under the provisions of Title 22 of the California Code of Regulations. Since 1998, significant portions of the Medi-Cal population have been enrolled into managed care organizations on a mandatory basis.

Regulatory Agencies

Blue Shield Promise Health Plan is subject to government regulations at local, state, and federal levels including the following:

- The Centers for Medicare and Medicaid Services (CMS) - Administers the regulations under which a Prepaid Health Plan operates as a Federally Qualified Health Maintenance Organization.
- The California Department of Managed Health Care (DMHC) - Establishes many requirements in the areas of financial reporting, required services, and continuity of care. It administers the Knox-Keene Act and the Knox-Mills Health Plan Act.
- The California Department of Health Care Services (DHCS) - Establishes requirements for the Medi-Cal Managed Care program. Blue Shield Promise Health Plan's contract with DHCS for San Diego County and with L.A. Care Health Plan for Los Angeles County, make Blue Shield Promise Health Plan subject to these regulations.

Regulatory Requirements for Network Providers

As defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract (Exhibit E, Attachment 1, Definitions) network providers must:

1. Have an executed written Network Provider Agreement with the managed care plan (MCP) or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of APL 19-001;
2. Be enrolled in accordance with APL 17-019, the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, and any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and
4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

SECTION 2: MISSION STATEMENT

Mission

Blue Shield of California Promise Health Plan's mission is to ensure that all Californians have access to high-quality health care at an affordable price.

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SECTION 3: BENEFITS

3.1: Covered Benefits

Blue Shield of California Promise Health Plan is contracted with the Local Initiative Health Authority of Los Angeles County (L.A. Care), and the Department of Health Care Services (San Diego) to provide Medi-Cal health benefits to its Medi-Cal recipients.

In order to provide the best health care services and practices, Blue Shield of California Promise Health Plan has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield Promise Health Plan Medi-Cal plans are described in the *Summary of Benefits* and the *Evidence of Coverage.* Providers can view these documents online by visiting our Provider Portal at https://www.blueshieldca.com/promise/medi-cal/index.asp. To request printed copies of the publications, please contact the Provider Customer Services Department at (800) 468-9935.

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SECTION 4: MEMBER RIGHTS AND RESPONSIBILITIES

4.1: Member Rights and Responsibilities

PURPOSE

To clearly outline Blue Shield Promise Health Plan's commitment to providing quality health care to its Members and to communicate to Members, Providers, and Staff the Member's Right and Responsibilities.

POLICY

1. It is Blue Shield Promise Health Plan's policy to provide quality health care to its Members. To assure Members of this commitment, Blue Shield Promise Health Plan has established these Member Rights and Responsibilities.
2. Blue Shield Promise Health Plan requires its Providers to understand and abide by these Member Rights and Responsibilities when providing services to our Members. Providers are informed of Member Rights through the Provider Manual and Provider Newsletters.
3. Blue Shield Promise Health Plan informs each Member of these Rights and Responsibilities in Member's Evidence of Coverage, which is distributed upon enrollment and annually thereafter.

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MEMBER RIGHTS AND RESPONSIBILITIES

What are your health care rights? You have the right to know.

- To know your rights and responsibilities.
- To know about our services, doctors, and specialists and be informed when your doctor is no longer contracted with Blue Shield Promise Health Plan.
- To know about all our other caregivers.
- To be able to see your medical records. You have to follow the State and Federal laws that apply.
- To have an honest talk with your doctor about all treatment options for your condition, regardless of cost or benefit coverage.

You have the right to be treated well.

- To always be treated with respect.
- To have your privacy kept safe by everyone in our health plan.
- To know that we keep all your information private.

You have the right to be in charge of your health care.

- To choose your primary care doctor.
- To say no to care from your primary care doctor or other caregivers.
- To be able to make choices about your health care.
- To make a living will (also called an advance directive).
- To voice complaints or appeals about Blue Shield Promise Health Plan or the care it provides including the right to file a grievance if you do not receive services in the language your request.
- To wait no more than 10 minutes to speak to a customer service representative during Blue Shield Promise's normal business hours.
- To get an appointment within a reasonable amount of time.

You have the right to get a range of services.

- To get family planning services.
- To get preventative health care services.
- To get minor consent services.
- To be treated for sexually transmitted diseases (STDs).
- To get emergency care outside of our network.
- To get health care from a Federally Qualified Health Center (FQHC).
- To get health care at an Indian Health Center.
- To get a second opinion.
- To get interpreter services at no cost. This includes services for the hearing-impaired.

- To get informing information materials in alternative formats and large size print upon request.

You have the right to suggest changes to our health plan.

- To tell us what you don't like about our health plan.
- To tell us what you don't like about the health care you get.
- To question our decisions about your health care.
- To tell us what you don't like about our rights and responsibilities policy.
- To ask the Department of Social Services for a Fair Hearing.
- To ask the Department of Managed Health Care for an Independent Medical Review.
- To choose to leave our health plan.

What are your responsibilities as a health care Member?

We hope you will work with your doctors as partners in your health care.

- Make an appointment with your doctor within 120 days of becoming a new Member for an initial health assessment.
- Tell your doctors what they need to know to treat you.
- Learn as much as you can about your health.
- Follow the treatment plans you and your doctors agree to.
- Follow what the doctor tells you to do to take good care of yourself.
- Do the things that keep you from getting sick.
- Bring your ID card with you when you visit your doctor.
- Treat your doctors and other caregivers with respect.
- Use the emergency room for emergencies only. Your doctor will provide most of the medical care that you need.
- Report health care fraud.

We want you to understand your health plan.

- Know and follow the rules of your health plan.
- Know that laws guide our health plan and the services you get.
- Know that we can't treat you different because of, age, sex, race, national origin, culture, language needs, sexual orientation, and/or health.

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SECTION 5: ENROLLMENT

5.1: Eligibility

Eligible members must reside within the Blue Shield Promise Health Plan approved service area and meet the requirements for Medi-Cal benefits. The State's Automated Eligibility Verification System (AEVS) is the ultimate determination of eligibility, while L.A. Care provides ultimate determination of plan partner assignment for members residing in LA County. Blue Shield Promise Health Plan provides the ultimate determination of eligibility for San Diego Members. As eligibility may change at any time, providers are required to verify member eligibility at time of service. Eligibility may change at any time, so providers are reminded to check Member eligibility at the time of each visit.

5.2: Member Enrollment

The Health Care Options (HCO) Program, under the California Department of Health Services (DHS), is responsible for the process of Member enrollment and disenrollment into and out of one of the two (2) plans contracted in L.A. County. The contracted plans are the local initiative plan, L.A. Care Health Plan (L.A. Care), and the commercial plan, Health Net in partner with Molina and Universal Care. A Member can choose his/her plan by completing a Health Care Options (HCO) plan selection form. If selected, L.A. Care is responsible for assigning Members into one of the five plan partners including Blue Shield Promise Health Plan. The five plan partners are Blue Shield Promise Health Plan, Community Health Plan, Kaiser Permanente, Blue Cross of California, and LA Care Health Plan.

5.3: Member Health Plan Selection

Medi-Cal beneficiaries in mandatory aid codes will be sent an enrollment package by HCO. The enrollment package will contain information on the local initiative plan and the commercial plan, as well as provider directories for each. Medi-Cal beneficiaries who receive an enrollment package have 30 days to select a plan and a primary care physician. The enrollment package will also contain a toll-free telephone number for HCO.

To enroll for Membership in L.A. Care/Blue Shield Promise Health Plan, a Medi-Cal recipient must complete a Medi-Cal Benefit Choice form (HCO form) which is available through Blue Shield Promise Health Plan, Health Care Options, or any Welfare Office. Members may call Blue Shield Promise Health Plan Member Services to obtain an HCO form at (800) 605-2556 or (TTY 711). To join Blue Shield Promise Health Plan, the Member must request L.A. Care/ Blue Shield Promise Health Plan on the HCO Form - section "Plan". They must also note the requested PCP license number - the PCP number followed by the letter "F". Forms must be mailed by the Member directly to HCO. PROVIDERS ARE NOT ALLOWED TO HAVE BLANK HCO FORMS IN THEIR OFFICES. The provider may assist a Member when a Member comes to the provider's office and asks for assistance in completing the HCO form that they have received.

Individuals in mandatory aid codes who do not select a plan will be defaulted into either of the two plans using a special assignment algorithm. If a Member defaults to L.A. Care, they will be assigned by HCO to one of the five plan partners. Recipients in voluntary aid codes may choose to be enrolled in a managed care health plan like Blue Shield Promise Health Plan if they so desire.

HCO is also responsible for disenrolling Members from Medi-Cal managed care when their Medi- Cal eligibility is lost or when an exemption request is submitted and accepted.

L.A. Care/Blue Shield Promise Health Plan is not responsible for any issue regarding Medi-Cal eligibility.

5.4: Coverage

Member coverage will begin at 12:01 a.m. on the first day of the calendar month for which the beneficiary's name is added to the approved list of Members furnished by L.A. Care to Blue Shield Promise Health Plan. All eligibility determination issues must be referred to the Member's County Department of Public Social Services (DPSS) eligibility worker.

5.5: Newborn Coverage

Coverage of the newborn begins at birth. The newborn is covered under the mother's Medi-Cal by Blue Shield Promise Health Plan for the month of birth and the month following as long as the mother's Medi-Cal eligibility remains active. The newborn is covered under the mother's Medi-Cal capitation payment to Blue Shield Promise Health Plan and its providers. In order to retain coverage for a newborn, parents must first apply for a social security number (SSN) for the newborn. After receiving a receipt for the SSN, the mother must apply for Medi-Cal coverage for the newborn or the newborn will lose coverage after their initial eligibility expires.

5.6: Change of Primary Care Physician

5.6.1: Member Initiated Change

Members may request a primary care physician (PCP) change during any given month. A Member may request a PCP transfer by calling Member Services. Each eligible Member in a family may select a different PCP.

All transfer requests received by Member Services by the 15th of the month will be effective on the first of that same month if the Member has not utilized any medical services. If services were rendered the transfer will not take place until the first of the following month. PCP transfers requested or received after the 15th of the month will be effective on the first of the following month that the request was made.

Note: All exceptions to this policy must be pre-authorized by the Member Services Manager/ Supervisor/Lead or Director prior to approving/ processing the transfer request. Each retroactive transfer request is reviewed and approved on an individual per case basis pending circumstances involved, access, and urgency of care. Prior to any change, inquiries will be made to assure there was no prior utilization of services during the month.

When the PCP change is processed and completed, a new ID card will be generated and sent to the Member. All PCP changes are processed by the Enrollment Unit and are noted in the Blue Shield Promise Health Plan Customer Service and Inquiry Module database by Member Services for future reference.

5.6.2: Primary Care Physician Initiated Change

Occasional circumstances may arise in which a PCP wishes to transfer an assigned Member to another PCP. In such cases, the PCP must submit a written transfer request to Blue Shield Promise Health Plan for approval to send a Member Notification Letter. The PCP must note the reason for the transfer request and provide written documentation to support the removal of a Member from their panel.

Upon receipt of a transfer request form, the Blue Shield Promise Health Plan Chief Medical Officer will evaluate the information presented and make a determination. The following are not acceptable grounds for a provider to seek the transfer of a Member:

- The medical condition of a Member
- Amount, variety, or cost of covered services required by a Member
- Demographic and cultural characteristics of a Member

Blue Shield Promise Health Plan will ensure that there is no Member discrimination for the above or any other reasons.

If the transfer request is approved, the provider will be asked to send an approved notification letter to the Member giving the Member 30 days to change their PCP. Blue Shield Promise Health Plan will contact and reassign the Member according to their choice considering geographic location, linguistic congruity, and other variables.

5.7: Eligibility List

Each Blue Shield Promise Health Plan Participating Provider Group "PPG" and directly contracted primary care physician is provided an eligibility file monthly of all of its assigned members via the national HIPAA compliant standard 834 5010 file format. The eligibility file is distributed by the 10th of each month via our secure file transfer protocol (SFTP) The eligibility files contains at the minimum but not limited to the following information listed below. *Providers participating with Blue Shield Promise Health Plan through a delegated PPG will receive eligibility within the format and timeframe established by the PPG.*

1. Month of Eligibility
2. Provider Name and Address, Provider Number
3. Member's Subscriber Number
4. Member's Last Name
5. Member's First Name
6. Date of Birth
7. Age
8. Social Security Number (new Members only)
9. Member's Address (new Members only)
10. Member's Telephone number (new Members only)
11. PPG Effective Date
12. Member's Medi-Cal Aid Code
13. Sex
14. Special Remarks

5.8: Eligibility Verification

Member eligibility should be verified from the Eligibility Roster at each visit. Should you have any questions about a Member's eligibility, please call Blue Shield Promise Health Plan, Provider Line at (800) 468-9935.

Eligibility Status (Class) Codes

01 = Eligible Member - Capitation paid
05 = Member on Hold Status - No Capitation Paid (Call Member Services for possible hold release)
59 = Member on Hold - Pending termination 09 = Member Disenrolled - No Capitation paid 00 = Member Voluntarily Disenrolled - No Capitation paid
99 = Disenrolled Member - No Capitation paid
Dep =Dependent Child-Covered under mother's cap for month of birth and following month

5.9: Identification Cards

Blue Shield Promise Health Plan will furnish each new Member with materials within the first seven (7) days of enrollment including:

- A welcome letter
- A Member Identification Card with the 24-hour emergency numbers for their primary care physician (PCP)
- An L.A. Care/Blue Shield Promise Health Plan Member Handbook (Evidence of Coverage)
- Blue Shield Promise Health Plan provider directory listing the days and hours of operation, address and telephone numbers for primary care physicians, hospitals, optometrists, pharmacies, skilled nursing facilities, and urgent care centers.
- Reminder card requesting the Member call and make their first (120-day health assessment) appointment.
- Fraud postcard containing phone numbers to report fraud.

The Member Identification Card is for identification purposes only and does not guarantee eligibility for Blue Shield Promise Health Plan or L.A. Care providers. You should always refer to your Eligibility Roster for current eligibility information, or call Blue Shield Promise Health Plan, Provider line at (800)468-9935 for eligibility verification.

In addition to the Blue Shield Promise Health Plan identification card, the Member will continue to use his/her Medi-Cal benefit information card (BIC) to receive services that may not be covered by Blue Shield Promise Health Plan or L.A. Care such as mental health services and glasses.

5.10: Disenrollment

Disenrollment refers to the termination of a Member's enrollment in L.A. Care and/or Blue Shield Promise Health Plan. It does not refer to a Member transferring from one primary care physician to another. Members may disenroll from Blue Shield Promise Health Plan and/or L.A. Care at their own discretion.

Under certain circumstances it may be mandatory to disenroll a Member from Medi-Cal Managed Care. Circumstances include a loss of Medi-Cal eligibility, relocation outside of Los Angeles County, or a change of aid code to a managed care ineligible code. Certain medical conditions, such as the need for major organ transplantation, result in mandatory disenrollment as well. For cases in which a disenrolled Member reverts to fee-for-service Medi-Cal, the former Member could feasibly continue to receive care from the same provider(s) on a fee-for-service basis. The disenrollment request will be processed by HCO and not through Blue Shield Promise Health Plan or L.A. Care's grievance process. Members are to send completed disenrollment forms directly to HCO.

5.11: Plan Initiated Disenrollment

Plan initiated request for disenrollment must be based on documentation validating that there has been a breakdown in the relationship between Blue Shield Promise Health Plan and the Member, or between the provider and the patient.

Request for disenrollment resulting from a breakdown in the provider/patient relationship must include documentation of any one of the following circumstances:

1. The Member is verbally or physically abusive to the provider, administrative staff or other Members.
2. The Member fails to follow prescribed treatment, or repeatedly fails to keep scheduled appointments.
3. The Member repeatedly uses providers not affiliated with Blue Shield Promise Health Plan for non-emergency services without prior authorization.
4. The Member persists in conduct that interferes with the effective rendition of health care.
5. The Member allows someone else to use their Blue Shield Promise Health Plan Identification Card.

Reasonable efforts should be made to:

1. Counsel or modify the Member's behavior.
2. Provide the Member the opportunity to develop an acceptable provider/patient relationship with another provider with the primary medical group.

These efforts must be documented and indicate that counseling has been unsuccessful if in fact that is the case. This will begin the Member's involuntary disenrollment process, which must also go through the grievance process.

5.12: Transportation

Non-emergency transportation is provided for all members who have no alternative means of transportation to assure access to providers. All members requesting transportation must be eligible with Blue Shield Promise Health Plan for the month that the transportation is requested. Transportation is offered to and from plan approved locations. Arrangement should be made at least 24 hours prior to the appointment by calling Blue Shield Promise Health Plan Member Services at: (877) 433-2178 (TTY 711).

5.13: Translation Services/California Relay Services

Blue Shield Promise Health Plan Members are culturally and linguistically diverse, representing many different countries and ethnic groups. Providers may access telephonic interpreters for all languages by calling Blue Shield Promise Health Plan Member Services. This service is available 24 hours a day, seven (7) days a week. Assistance for the hearing impaired can be accessed telephonically through the California Relay Service.

Face-to-face interpretive services are also available for Blue Shield Promise Health Plan Members, including the hearing impaired, by calling Blue Shield Promise Health Plan Member Services at (800) 605-2556 (TTY 711) no less than 5 – 7 days in advance.

SECTION 6: GRIEVANCES, APPEALS AND DISPUTES

6.1: Member Grievances

Purpose

Blue Shield Promise Health Plan has established a system for Members to communicate problems and concerns regarding their health care and to receive an immediate response through the Plan's grievance system. This is outlined in the Member Grievance Policy and Procedure Manual, which may be obtained from Blue Shield Promise Health Plan. There are 2 categories of Grievances:

- Quality of Care – Allegations of substandard care that could impact clinical outcomes.
- Quality of Service – Allegations that service did not meet standard.

Procedure

Members are encouraged to speak with their Medical Group/PCP regarding any questions or concerns they may have. Members may also communicate their concerns directly to Blue Shield Promise Health Plan Member Services by telephone at (800) 605-2556 (TTY (800) 735- 2929), in writing by completing a Member Grievance Form (See Appendix 1 or 2) by email, or in person.

Grievances can be filed by telephone, in writing, or in person. Blue Shield Promise Health Plan will acknowledge receipt of all written formal grievances within five (5) business days. Blue Shield Promise Health Plan will resolve grievances within 30 days and provide a resolution letter to the Member. Providers and Participating Provider Groups (PPG) are required to provide Medical Records, Authorizations or responses within 7 calendar days of the request in order to resolve the grievance within the regulatory timelines.

If the resolution of the appeal/grievance is not acceptable to the Member or if a grievance has remained unresolved for more than 30 days, he/she has the right to contact the California.

Department of Managed Health Care (DMHC) for assistance. The DMHC is responsible for regulating health care service plans. If a Member has a grievance against Blue Shield Promise Health Plan, he/she should first use the Blue Shield Promise Health Plan grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the Member. Members may also be eligible for an Independent Medical Review (IMR) to provide an impartial review of medical decisions made by a health plan. The IMR will determine the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

If a Member is not satisfied with a Blue Shield Promise Health Plan decision or the grievance process, or needs assistance with a grievance, he/she may contact the DMHC at (888) 466-2219 (TTY (877) 688- 9891) or access its website at http://www.dmhc.ca.gov. Instructions, complaint forms, and IMR application forms are available on the DMHC website.

Medi-Cal Members also have the right to request a State Fair Hearing within 120 days of the notification if the resolution of the appeal/grievance is unacceptable to the member. For more information about State Fair Hearing requests, Members may call the California Department of Social Services (DSS) at (800) 952-5253 (TTY (800) 952- 8349). The Ombudsman Office of the California Department of Health Services (DHS) is also available to Medi-Cal beneficiaries for help with grievances at (888) 452-8609.

Grievances concerning quality of care issues are reported immediately to the Quality Management (QM) Department. The QM Department logs the grievance, gathers medical records/information concerning the grievance, and reviews the case for quality of care. All quality related grievances are reviewed by the Medical Director. All grievances are tracked by type/category and by provider and are reviewed regularly by the QM Committee for potential quality of care issues. Blue Shield Promise Health Plan is primarily responsible for establishing and administering grievance procedures. However, the PPG/Medical Group and/or the PMG/PCP must participate with Blue Shield Promise Health Plan by providing assistance and information. Grievance forms shall be made available to Members at each PMG/ PCP site. Additionally, providers are given the opportunity to review all Member concerns and respond to the issues identified.

Letters of resolution on all levels of the dispute process will include detailed instructions about the Ombudsman program, the option of filing a State Fair Hearing Request with the California Department of Social Services (DSS), and/or how to request an IMR with the State Department of Managed Health Care (DMHC).

Expedited Grievance

The Member may request an expedited grievance when an imminent and serious threat to the health of the beneficiary exists, including but not limited to, severe pain or potential loss of life, limb or major bodily function that do not involve the appeal of an Adverse Benefit Determination, but are urgent in nature.

6.2: Member Appeals Requests

Providers and PPGs are required to provide medical records, authorizations and/or responses within 3 calendar days of the request for non-urgent cases in order to resolve the issue within the regulatory timelines.

The definition of an Appeal is: The Request for Reconsideration which follows a denial or unfavorable Coverage/Initial Determination.

The Examples of Appeals are:

1. Benefit Appeals – Involving care the plan specifically excludes from coverage (e.g., circumcision, cosmetic surgery etc.).
2. Medical Necessity – Covered Services that are necessary and appropriate for the treatment of a Member's illness or injury according to professionally recognized standards of practice

Appeals can be:

Pre Service - Prior to the Member receiving the requested item or service.

Post Service - The service has been rendered and there is a dispute about non-coverage of a claim.

An appeal can be:

Standard - Resolved in 30 calendar days.

Expedited - When the Member's life, health or ability to attain, maintain or regain maximum function is at risk.

Each Appeal begins the process anew (Denovo) to establish the story including:

1. The Member's perception.
2. The summary of the issue.
3. The Authorization Request.
4. The denial notice.
5. The evidence including Medical Records, clinical notes, submissions by Member or provider.
6. A summary of the State Rules, Regulations and Laws.
7. Summary of the Plan Language (EOC), Medical Policies, Manuals.

The staff involved in preparing and reviewing an appeal may not have been involved in the initial adverse decision/denial, or a subordinate/directly supervised by such person. In addition, for appeals involving clinical issues, the health care practitioner must have appropriate training and experience in the field of medicine involved in the medical judgment that requested the service.

6.2.1: Expedited Appeal

A provider or Member may file an expedited appeal to an adverse benefit determination and ask to have it processed expeditiously. This type of appeal is generally used in a continued stay or continued treatment situation, and when indicated based on the critical clinical condition of the Member. The following circumstances may, but are not limited to, constitute an expedited appeal:

- The Member has been issued a denial for service and:
- The Member is scheduled for ongoing services or admission to a hospital within 72 hours
- The Member suffers from a terminal illness
- The Attending Physician indicates in writing the Member's health will suffer adverse consequence from the denial decision

1. All requests for expedited appeals will be triaged by licensed personnel to determine whether the appeal meets expedited criteria
2. Documentation will be collected and presented to a Medical Director so that the case can be resolved and closed to the Member within 72 hours

6.3: Independent Medical Review

The independent medical review (IMR) process is an expansion of the appeal process for health plan enrollees. Independent reviews are conducted through the Department of Managed Health Care (DMHC) by an accredited impartial independent review organization to perform the medical review of a Plan/PPG/ Medical Group's decision to deny, modify or delay health care services, based in whole or in part on a finding that the disputed services are not medically necessary.

The enrollee may request the IMR within 180 days of any qualifying periods or events. The enrollee shall pay no application or processing fee of any kind.

Upon notice to the Plan from the department that an enrollee has applied for an IMR, the Plan and the Plan's contracted provider shall provide to the IMR organization all of the following documents within 24 hours if expedited or 48 hours if standard:

A copy of the Members medical records that is relevant to the following:

1. The Member's medical condition.
2. The healthcare services being provided by the Plan and its contracted provider for the condition.
3. The disputed health care services requested by the enrollee for the condition.

Independent Medical Review for Experimental/Investigational Procedures

The IMR also includes therapies, which have been denied by the Plan as experimental or investigational. Experimental/investigational procedures or treatments are a limitation to the Health Plan's evidence of coverage. These IMR requests do not have to first go through the Blue Shield Promise Health Plan Health Plan Appeal process.

Members That Qualify to Request the Experimental & Investigational Review Process

The external independent review process applies to Blue Shield Promise Health Plan Members that meet all of the following criteria:

1. The Member has a life threatening or seriously debilitating condition. ***"Life threatening"*** is defined as either or both of the following:
   a. Diseases or conditions where likelihood of death is high unless the course of the disease is interrupted.
   b. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

   "Seriously debilitating" Is defined as diseases or conditions that cause major irreversible morbidity, i.e. there is an imminent and serious threat to the health of the Member including severe pain, the potential loss of limb, or major bodily function.
2. The Member's physician certifies that the Member has a condition, as defined in Criteria 1 (above), for which standard therapies have not been effective in improving the condition of the Member, or for which standard therapies would not be medically appropriate for the Member, or for which there is no more beneficial standard therapy covered by the plan than the therapy proposed pursuant to Criteria 3 (below); and
3. Either (a) the Member's physician, who is under contract with or employed by Blue Shield Promise Health Plan, has recommended a drug , device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the Member than any available standard therapies; or (b) the Member, or Member's physician who is a licensed board-certified or board- eligible physician qualified to practice in the area of practice appropriate to treat the Member 's condition, has requested a therapy that, based on two (2) documents which meet the definition of " medical and scientific evidence" as defined by Health and Safety Code 1370.4 subsection d, is more likely to be more beneficial for the Member than any available standard therapy; and
4. The Member has been denied coverage by Blue Shield Promise Health Plan for a drug, device, procedure, or other therapy recommended or requested.
5. The specific drug, device, procedure or other therapy recommended would be a covered service, except for a Blue Shield Promise Health Plan determination that the therapy is experimental or investigational.

Criteria Determining Experimental/Investigational Status

In making a determination that any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply is "experimental or investigational" by the Plan, the Plan shall refer to evidence from the national medical community, which may include one or more of the following sources:

1. Evidence from national medical organizations, such as the National Centers of Health Service Research.
2. Peer-reviewed medical and scientific literature.
3. Publications from organizations, such as the American Medical Association (AMA).
4. Professionals, specialists, and experts.
5. Written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device, or medical treatment.
6. An expert physician panel selected by one of two organizations, the Managed Care Ombudsman Program of the Medical Care Management Corporation or the Department of Managed Health Care.

6.4: Provider Disputes – Claims Processing

Purpose

To establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes in accordance with H&S §1371.37.38.9.

6.4.1: Provider Questions, Concerns and Disputes

Providers can communicate questions and issues regarding their contract or that are not payment related to the Blue Shield Promise Health Plan Provider Network Operations (PNO) Department.

All provider payment related issues should be directed to the Provider Dispute Resolution (PDR) Department in writing. Examples of a payment related dispute are non-payment or underpayment of claims by Medical Groups/PPGs. All payment disputes are entered in the PDR database, investigated and a response will be provided in writing within the regulatory timeframe. Disputes are acknowledged within 15 working days and a resolution letter will be sent within 45 working days. Payment can take up to 5 days after the closure of the case.

6.4.2: Reconsiderations

A provider will have the ability to furnish the Blue Shield Promise Health Plan Provider Dispute Department with any additional information or documentation that may have a bearing on the initial determination of a request for authorization that has been previously denied, deferred, and/or modified.

Procedure for Reconsideration

1. A provider requesting reconsideration may call, fax, or submit in writing any additional information to the Blue Shield Promise Health Plan UM Department to support the original authorization request. The fax number for the UM Department is (323) 889-6214.
2. A reconsideration request will occur within one (1) business day upon receipt of the provider telephone call, written or faxed request.
3. The additional information will be reviewed by the Chief Medical Officer (CMO) of Blue Shield Promise Health Plan or his/her designated physician reviewer.
4. If the CMO or designated physician reviewer reverses the original determination based on additional information provided by the provider, an approval letter will be sent to the Provider and the Member.

If reconsideration does not resolve a difference of opinion, the provider may then submit an appeal in writing to the Provider Dispute Department.

6.4.3: Provider Disputes Policy and Procedure

Providers may submit a written dispute to the Blue Shield Promise Health Plan Provider Dispute Department. Disputes may pertain to issues such as authorization or denial of a service; non- payment or underpayment of a claim; or disputes with our delegated entities. All written, formal disputes will be responded to in writing. Upon receipt of the written dispute specifying the issue of concern, the dispute will be entered into the provider dispute database. An acknowledgement letter will be sent to the provider within fifteen working days of receiving the written dispute.

All provider disputes must be submitted in writing. If a provider attempts to file a provider dispute via telephone, Blue Shield Promise Health Plan staff will instruct the provider to submit the provider dispute to Blue Shield Promise Health Plan in writing. Information about how to file a dispute can be found on the Blue Shield Promise Health Plan website at https://www.blueshieldca.com/promise/providers/index.asp?secProviders=provider-disputes.

A provider can submit a provider dispute in writing to Blue Shield Promise Health Plan by mail. All provider disputes are forwarded to the appropriate department for processing.

6.4.4: First Level Appeal

A provider may appeal a denial decision made by Blue Shield Promise Health Plan or one of its PPG's. Blue Shield Promise Health Plan will refer clinical provider appeals and other appropriate cases for clinical review.

When the appeal is referred for clinical review:

1. All parties concerned shall be notified that a referral has been made for a clinical review within 15 working days and a final determination will be made within 45 working days from the date that Blue Shield Promise Health Plan received the dispute.
2. The clinical reviewer shall evaluate the medical records and submit his/her findings and recommendations to the Physician Reviewers for approval.

The Blue Shield Promise Health Plan Provider Dispute Department shall send a written letter of resolution outlining its conclusions with background information within 45 working days of receipt of the appeal. Language in the letter will include the any available next steps the provider can take with the dispute. Blue Shield Promise Health Plan shall retain all documentation related to the clinical review for a minimum of (5) five years.

6.4.5: Second Level Appeal

After completing a first level appeal, for L.A. County Medi-Cal only, the provider may submit a second level appeal. A second level appeal must be filed within 30 calendar days of receipt of the Blue Shield Promise Health Plan letter of resolution. It can also be used when Blue Shield Promise Health Plan has failed to act within the deadlines set forth above.

Medi-Cal providers seeking a second level appeal, disputes can be filed with Blue Shield Promise Health Plan or L.A. Care. If it is sent to Blue Shield Promise Health Plan, the Provider Dispute Unit will forward the request to L.A. Care with all material and documentation utilized in the First Level Appeal upon request. If a provider appeals directly to:

1. A letter requesting a review of the first level appeal.
2. A copy of the letter sent to Blue Shield Promise Health Plan requesting a first-level appeal.
3. A copy of the original documents submitted to Blue Shield Promise Health Plan.
4. A copy of the first level appeal - denial response letter if the second level of appeal is based on a denial.
5. A copy of any other correspondence between Blue Shield Promise Health Plan and the provider that documents timely submission and the validity of the appeal.

L.A. Care shall acknowledge the Second Level Appeal request by the provider within 15 working days of its receipt. L.A. Care shall review the written documents submitted in the provider's appeal, and if necessary, request additional information and/or hold an informal meeting with the parties involved. L.A. Care shall send a written letter of resolution outlining its reasons and conclusions, if appropriate, to the provider and the Plan within 45 working days of receipt of the appeal from the provider.

6.5: Attachments

See Appendix 1 and 2 of this manual for Member Grievance Forms and instructions.

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SECTION 7: UTILIZATION MANAGEMENT

7.1: Utilization Management Program

Mission Statement

The Blue Shield Promise Health Plan Utilization Management (UM) Department is committed to providing healthcare that is medically excellent, ethically driven, and delivered in a Member-centered environment. It recognizes the positive relationship between health education, a culture of wellness, and an emphasis on prevention and the cost-effective delivery of care.

Purpose

The purpose of the UM Program is to ensure consistent delivery of the highest quality health care and to optimize Member outcomes. This is accomplished through the establishment of fully integrated multidisciplinary healthcare networks and coordination of all clinical and administrative services under the provisions of the Blue Shield Promise Health Plan UM Program.

Goals

- Consistently apply UM standards, guidelines, and policy/procedures in the evaluation of medical care and services on a prospective, concurrent, and retrospective basis.
- Provide access to quality healthcare services delivered in the most appropriate and cost-effective setting.
- Facilitate and ensure continuity of care for Blue Shield Promise Health Plan Members within and outside of the Blue Shield Promise Health Plan provider network.

7.1.1: Physician, Member, and Provider Responsibilities

All Members shall select and are assigned to a Primary Care Physician (PCP). The PCP coordinates the entire spectrum of care for assigned Members. This includes direct provision of all primary healthcare services, including preventive health services.

Additional activities and responsibilities include:

- Provide appropriate and cost-effective care consistent with the Blue Shield Promise Health Plan UM Program, its protocols, standards, and guidelines.
- Submit complete and timely claims/encounters to Blue Shield Promise Health Plan for processing. Information generated from this data will be shared with provider participants at the discretion of the UM Committee. Blue Shield Promise Health Plan shall have access at reasonable times and upon reasonable demand to the participating physicians' books, medical records, and papers (consultation reports, x-rays, test results, charts, operative reports, etc.).

- Refer Members within the Blue Shield Promise Health Plan contracted network to the fullest and most reasonable extent possible. (Out-of-network referrals require prior approval).
- Assist in the evaluation of medical appropriateness of care provided to their Members or of care provided by other networks or non-network physicians, either on an individual basis or as part of the UM Committee.

7.1.2: Organization of Health Care Delivery Services

Health care services are provided through a combination of direct contracts, a full and shared risk network model, structured to provide a continuum of care. Contracted network providers include, but are not limited to, PCPs, specialty physicians, community and tertiary hospitals, skilled nursing facilities, home health agencies, pharmacies, laboratories, durable medical equipment providers, and others.

Non-emergent care other than self- referable, direct-access care requires by the Blue Shield Promise Health Plan UM Department or by the delegated financially responsible entity. Whenever medically appropriate, services will be arranged with network providers. This does not preclude the use of non-network providers when medically appropriate, as defined in other areas of this document.

7.1.3: Medical Services Structure Membership

The Medical Services Committee is chaired by the Blue Shield Promise Health Plan Chief Medical Officer (CMO). Membership is assigned and includes PCPs and a representative sample of specialty care physicians. The term of Membership is one (1) year with reappointment by the Committee and approval by the Board of Directors. There is no limit on the number of consecutive terms that assigned physicians may serve.

Meetings

The Medical Services Committee meets on a quarterly basis and is responsible for the following:

- Reviewing and discussing administrative information presented to the Members.
- Reviewing Utilization Management statistics.
- Receiving, reviewing, evaluating and making recommendations regarding UM activities.
- Reviewing proposed Member treatment plans that require input beyond the expertise of the CMO with specialty advisors.
- Coordinating educational opportunities for physicians regarding UM procedures and processes.

Confidentiality

All committee Members and participants, including medical staff, participating providers, consultants, and others will maintain the standards of ethics and confidentiality regarding both Member information and proprietary information.

Reports

The following reports are reviewed by the UM Committee and the Board of Directors:

- Total hospital bed days per 1000
- Total number of referrals by specialty
- Total number of referrals approved, deferred, and denied
- Turnaround time studies
- Appeals
- E.R. Utilization
- CCS Cases
- Pharmacy Utilization

7.1.4: UM Review Process for Appropriateness of Care

Procedures are utilized for the review process. Benefit algorithms have been developed to allow particular referrals to be automatically authorized by the UM coordinators. This process can reduce the number of referrals not requiring clinical expertise for determination. Referrals that involve medical information and criteria go to the Case Managers or physician reviewers. A physician

will conduct a review for medical appropriateness on any denial. When necessary, the CMO will consult with physicians from the appropriate specialty areas of medicine and surgery, who are certified by the applicable American Board of Medical Specialists, for any medical decision that requires this level of expertise. A list of these physician consultants is also available to the CMO for second opinions, reconsiderations and appeal requests.

All PPG's contracted with Blue Shield Promise Health Plan may only utilize Blue Shield Promise Health Plan approved criteria as listed below. PPG's must first use Medi-Cal Guidelines for medical necessity determination and only use the others when Medi-Cal Guidelines are not available. The following is a complete list of the Blue Shield Promise Health Plan approved guidelines or sources that may be utilized for issuing approvals, denials or modifications. PPG/MSO Internal Policy or guidelines should not be used for any medical necessity determination on a Blue Shield Promise Health Plan member, all benefit denials should either reference a Medi-Cal source or the Blue Shield Promise Health Plan Explanation of Coverage (EOC).

Medi-Cal
Medi-Cal Guidelines
MCG 23rd Edition
Up to Date
Nelson Textbook of Pediatrics
National Guideline Clearinghouse
Hayes
NCCN
Blue Shield Promise Health Plan Evidence of Coverage (EOC)

Medical necessity is determined by the review of medical information provided by the requesting physician, hospital medical records, and physician to physician communication. The review is done prospectively, concurrently and retrospectively.

Reviewer Availability

The Chief Medical Officer (CMO) is available to discuss any UM decision. Practitioners can call CMO at (800) 468-9935 from 9 A.M – 6 P.M Monday – Friday.

7.1.5: Review Criteria

The UM Department uses nationally developed and accepted review criteria, i.e. Milliman Care Guidelines, the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, the United States Preventative Services Task Force Standards, Comprehensive Perinatal Service Program Guidelines, and Title 22. A review of criterion is updated on an ongoing basis.

Nationally recognized criteria sets will be renewed at least every two (2) years. The criteria sets alone cannot ensure consistent UM decision making across the organization. Additionally, Blue Shield Promise Health Plan recognizes that individual needs and/or circumstances may require flexibility in the application of the Plan's delivery system.

The UM review criteria is available for disclosure to providers, Members, and the public upon request either in writing or by contacting Blue Shield Promise Health Plan UM Department at (800) 468-9935.

The Blue Shield Promise Health Plan UM Program consists of the following functions and activities. Each is individually explained in specific policy and procedure:

- Specialty Care Referral Management
- Ancillary Provider Care Referral Management
- Outpatient and Ambulatory Services Review
- Elective Admission Review
- Assistant Surgeon Review
- Referral Turn Around Time Frames
- Authorization Validity
- Emergency Services Utilization Review
- Urgent/Emergent Admission Review
- Concurrent Utilization Review
- Discharge Planning
- Second Opinions
- Out-of-Network Referral Management
- Postpartum Health Mother and Baby Program
- Retrospective Utilization Review
- Family Planning Services
- Self-Referable Services
- Standing Referral/Extended
- Direct OB-GYN Access Program
- Sterilizations
- Sensitive Minors
- Sexually Transmitted Disease Services
- Evaluation and Review of Experimental and Investigational Therapies
- Reconstructive Surgery
- Denials
- Reconsideration
- Grievance and Appeal Process
- Expedited Appeals Review
- Pharmacy and Medication Utilization Review
- Organ Transplants
- Vision Care
- Various Linked Programs
- WIC Program Services
- Medi-Cal Waiver Program Services
- CHDP
- California Children's Services
- Medical Mental Health
- Healthy Families Mental Health

- Healthy Families Seriously Emotionally Disturbed (S.E.D.)
- Drug and Alcohol
- Hospice
- T.B.
- E.P.S.D.T.
- C.P.S.P.
- Long Term
- Early Start
- Dental

7.2: Complex Case Management Program

Mission Statement

To work collaboratively with healthcare providers across a full spectrum of healthcare settings by focusing on the attainment of optimal health outcomes through the identification and management of high-risk enrollees with catastrophic illnesses, complex diagnoses, and or selected disease related conditions.

Purpose

The Blue Shield Promise Health Plan Case Management Program is developed as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs. This purpose is implemented through communication and use of available resources to promote quality and cost-effective outcomes. The Blue Shield Promise Health Plan Case Management Program is developed to specifically address the needs of the Member with high cost, high volume, and high-risk health care experiences.

The Case Management Program is established to specifically identify eligible candidates that may benefit from the program by diagnostic/symptomatic categorization at initial points of service, with a focus on early identification of risk factors, and conducting a needs assessment. The goal is to identify and intervene early to affect the best outcome for the catastrophically impacted, chronically ill, injured, or high chronically ill, injured, or high-risk OB Members.

7.2.1: The Role of the Case Manager

Case Managers will work with PCPs to evaluate a Member for the program and assess the Member's condition and social situation for a needs determination. An eligibility benefits determination will be made and compared with the Member's needs. A comprehensive program will then be developed to identify benefit and community resource utilization. Members will be referred to Complex Case Management in the community from various sources, via pre- certification, during hospitalization, while receiving ancillary services or claims.

Once accepted into the Case Management Program, the Case Manager will develop a plan of care. Appropriate referrals will be made to community resources. The Case Manager will monitor and evaluate the case and revise the plan as appropriate until its conclusion. A case will be closed for the following but not limited to:

- No longer meets medical necessity for the benefit
- Terminates from the plan
- Expires
- Refuses further case management services

7.2.2: Case Management in the Ambulatory Setting

A Case Management Program referral may be received from several sources including:

- Referral Coordinator
- Member Services
- Quality Assurance
- PCP office setting
- Family telephone call with request for Case Management
- Referral from Claims Department
- Referral from Pharmacy Department

Information will be collected about the Member and the case including: demographic information (name, birth-date, most recent ad dress and telephone number, nearest relative with a telephone number, significant person/caretaker); social history (employment, education and training, life style, religious concerns which may impact any case management plan, in-home family structure, residing in a facility, receiving day care or in-home supportive services); and clinical information (should consist of a history and recent clinical information that is related to the diagnoses being evaluated for case management). This information may be obtained by/from many sources, including:

- PCP office nurse or other staff. (A request for medical information may be sent to the PCP office staff that may fax or send the information for the case management record.) If the information is needed on an emergent basis, the information may be obtained over the telephone. Use the request for information letter, if appropriate.
- Current service provider(s) (Occupational/Physical/Speech Therapy, Home Health, surgery, etc.). These providers often have complete records.
- The Member and/or their responsible party/caretaker.
- Specialist(s) involved in the case.

A case management problem can be identified from a variety of sources such as diagnoses and contracted benefit. For example:

- Fractured wrist with surgical repair = suture/wound care, dressings or not, equipment needs, caregiver with instruction, PT/OT needs
- Depression = mental health care
- Fractured leg with cast = PT, crutch, transportation
- Abdominal wound = home health, dressings, and teaching/caregiver
- Absorption/digestive problems = nasogastric/gastrostomy tube and related
- supplies, liquid nutritional product, instructions to caregiver, monitoring by physician, (Gastroenterologist vs. PCP)
- Major musculoskeletal abnormalities = durable medical equipment and supplies, OT/ PT/Speech, caretaker issues/respite, educational needs, incontinent supplies, ADL adaptations
- High-risk OB with symptoms = fetal monitoring, complete bed rest at home, IV therapy

A case management problem can also be one of the following social/clinical issues, which will impact the ability of the Member to overcome the current problem:

- Inadequate parent knowledge
- Parent illness
- Lives alone, or only adult in the household while enduring illness
- Lack of transportation
- Refusal of service
- Treatment recommended is contrary to client belief system
- Mental illness/substance or chemical addiction
- Violent home

- Homeless, living in a shelter or residential treatment center

A benefit evaluation will measure which resource can best provide for the needs of the client:

- CCS
- WIC
- Regional Center
- Alcohol and substance abuse program
- Mental Health
- HIV/AIDs programs
- Waiver program
- Dental services
- Genetically Handicapped Disability Program
- Vision care
- Home Health
- Early Prevention, Screening, Diagnosis, and Treatment (EPSDT)/Child Health and Disability Prevention (CHDP), Early Intervention/ Early Start/Developmental Disabilities Services (EI/ EI/DDS)
- Contractual benefits of Blue Shield Promise including: Organ transplant evaluation

The Case Management Database is to be maintained by following these steps:

1. Write out the case management interventions that are planned, including the number or length of the service to be authorized.
2. Review the plan with the designated Health Plan physician, Medical Group physician, appropriate treating physicians, caregivers, and providers of service.
    a. Fax completed authorizations to physician(s) for signature and return to Case Management.
    b. Identify contact persons for each person and request regular written progress reports.
3. Send an Introduction to Case Management Letter to the Member and/or his or her family.

7.2.3: Case Management in the Inpatient Setting

Inpatient Case Managers are licensed nurses and are responsible for the daily utilization review of acute hospital, skilled nursing, psychiatric, and rehabilitation inpatient stays. They interface with the in-house physicians and the Chief Medical Officer to assure continuity of care in the most appropriate setting. Immediately upon notification of admission they begin the process of case assessment and the coordination of discharge planning with the focus of medical necessity. Additional functions are as followed:

- Monitor, document, and report pertinent clinical criteria as established per UM Policy and Procedures to Medical Director and other designated sources.
- Identify and report to quality management referral indicators and submit data for ongoing studies.
- Interface daily with hospital employed discharge planners, Case Managers, and social workers to collaborate and coordinate all identified Members' needs to promote the most expeditious return of his/her optimal level of function prior to hospitalization.
- Coordinate all services for discharge in timely manner and with contracted providers.

7.3: Primary Care Physician (PCP) Scope of Care

The list below includes, but is not limited to, services considered PCP functions. A PCP's scope of care is dependent on the level of training the physician has received, the limitations of scope of practice, and uniformity with State and Federal rules and regulations. (These guidelines are based on routine uncomplicated cases that are ordinarily seen by a PCP).

OFFICE/CLINIC:

Allergy:

- Allergy history
- Treat seasonal allergies, hives and chronic rhinitis
- Environmental counseling
- Minor insect bites/stings
- Asthma, (chronic/acute) active with or without co-existing infection
- Peak flow monitoring

Cardiology:

- Perform and interpret electrocardiograms
- Evaluate chest pain, murmurs, palpitations
- Evaluate and treat coronary risk factors, including smoking, hyperlipidemia, diabetes, HTN, lifestyle
- Evaluate and treat CHF, stable angina, non-life-threatening arrhythmias
- Evaluate syncope (cardiac and non-cardiac)
- Provide education and prophylaxis against rheumatic fever or bacterial endocarditis when appropriate

Dermatology:

- Treat acne (acute and recurrent)
- Treat warts with topical suspensions, electrocautery, liquid nitrogen
- Diagnose and treat common rashes including: Contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, seborrheic dermatitis and tinea versicolor
- Identify suspicious moles
- Screen for basal or squamous cell carcinomas
- Diagnose and treat common hair and nail problems and dermal injuries
- Common hair problems including: fungal infections, ingrown hairs, virializing causes of hirsutism, or alopecia as a result of scarring or endocrine effects
- Common nail problems including: trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections, and ingrown nails
- Dermal injuries including: minor burns, lacerations, and treatment of bites and stings
- Counsel Members regarding removal of cosmetic (non-covered) lesions
- Diagnose and treat irritated seborrheic keratosis
- Treat irritated skin tags < 5
- Manage mild stasis ulcers
- Treat actinic keratosis excluding face with liquid nitrogen or Efudex

Endocrinology:

- Diabetic management and education including Type I and Type II patient
- Member education
- Supervision of Home Blood Glucose Monitoring Testing (coordinate telephonically with Member or via home health nurse)
- Diagnose and treat thyroid disorders including multi-nodular goiter
- Identify and treat hyperlipidemia
- Obesity management, diet instruction, exercise instruction
- Provide Member education and treatment for osteoporosis

Gastroenterology:

- Diagnose and treat lower abdominal pain
- Diagnose and treat acute diarrhea
- Treat protracted vomiting
- Occult blood testing
- Diagnose and treat heartburn, upper abdominal pain, pancreatitis, hiatal hernia, acid
- peptic disease, reflux
- Diagnose and treat functional bowel syndrome
- Diagnose and treat chronic jaundice under SCP recommendations
- Diagnose and treat chronic ascites under SCP recommendations
- Diagnose and treat symptomatic, bleeding or prolapsed hemorrhoids
- Manage stable inflammatory bowel disease under SCP recommendations
- Diagnose and treat uncomplicated hepatitis

- Diagnostic endoscopy
- Screen for colon cancer according to recommended schedule

General Surgery:

- Evaluate and follow small breast lumps
- Order screening mammogram according to approved schedule
- Local minor surgery for hemorrhoids
- Incision and drainage of simple soft tissue infections
- Suture removal
- Evaluate hernias (incisional, inguinal, femoral, ventral)
- Diagnose symptomatic gallbladder disease

Gynecology:

- Perform routine pelvic exams, PAP smears, birth control, and breast exam.
- Diagnose and treat vaginitis sexually transmitted disease s including pelvic inflammatory disease
- Evaluate lower abdominal pain to distinguish gynecological from gastrointestinal causes
- Diagnose and treat abnormal vaginal bleeding (excluding post-menopausal bleeding)
- Manage stable endometriosis with analgesics and NSAIDs
- Manage premenstrual syndrome with non-steroidal anti-inflammatory agents, diuretics and other symptomatic treatment
- Diagnose pelvic masses and fibroids
- Manage post-menopausal syndrome
- Provide counseling and manage estrogen replacement therapy
- Screen for prenatal and postpartum mental health conditions and refer for mental health services as appropriate

Hematology:

- Initial differential diagnosis of anemia
- Treat iron deficiency, B12 and folic acid deficiency
- Recognize anemia of chronic disease
- Evaluation and treatment of stable Sickle Cell Disease

Infectious Disease:

- Common infectious diseases (respiratory, gastro-intestinal, dermatological, venereal, urological, gynecological)
- Initial evaluation for HIV positive
- Viral disorders
- Tuberculosis treatment and prophylaxis

Nephrology:

- Evaluate renal failure
- Evaluate proteinuria
- Evaluate and treat common electrolyte and acid-base abnormalities

Neurology:

- Diagnose and treat psycho-physiological diseases; headaches, low back pain, myofascial pain syndromes, neuropathies and radiculopathies
- Diagnose and treat tension and migraine headaches
- Treat syncope (cardiac and non-cardiac)
- Treat uncomplicated seizure disorders after SPC neurological evaluation
- Manage degenerative neurological disorders with respect to general medical care
- Treat stroke and TIA Members
- Manage dementia, and stable Parkinson's disease

Ophthalmology:

- Perform thorough ophthalmologic history including symptoms and subjective visual acuity
- Perform common eye related services including: distant/near testing, gross visual field testing by confrontation, alternate cover testing, direct funduscopy without dilation, extra ocular muscle function evaluation, red reflex testing in pediatric Member
- Diagnose and treat common eye conditions including: viral, bacterial and allergic conjunctivitis, blepharitis, hordeolum, chalazion, small subconjunctival hemorrhage, dacryocystitis, and sty
- Removal of simple superficial corneal foreign bodies (i.e. eyelash)

Orthopedics:

- Treat cervical, thoracic and lumbar back pain
- Treat sprains, strains, pulled muscles, overuse syndromes
- Treat inflammatory conditions
- Conservative treatment of chronic knee problems
- Manage chronic pain problems

Otolaryngology:

- Treat tonsillitis and streptococcal infections
- Perform throat cultures
- Evaluate and treat oropharyngeal infections: Stomatitis, Herpes simplex
- Treat acute otitis media and otitis external
- Treat serous effusion
- Evaluate tympanograms/audiograms
- Treat acute and chronic sinusitis
- Treat allergic or vasomotor rhinitis
- Remove ear wax, ear irrigations
- Diagnose and treat acute parotitis and acute salivary gland infections
- Evaluate neck masses
- Evaluate and treat epistaxis

Podiatry:

- Basic diabetic foot care and counseling
- Initial management of ingrown toenail, to include soaking, trimming and antibiotic treatment
- Diagnose and treat common foot problems: corns/calluses, bunions

Pulmonology:

- Diagnose and treat asthma, acute bronchitis, pneumonia
- Diagnose and treat chronic bronchitis
- Diagnose and treat chronic obstructive pulmonary disease and emphysema
- Manage home aerosol medications and oxygen
- Work up possible tuberculosis or fungal infections
- Promote smoking cessation

Rheumatology:

- Diagnose and treat non-articular musculoskeletal problems: Overuse syndromes, injuries and trauma, soft tissue syndromes, bursitis or tendonitis
- Manage osteoarthritis.
- Diagnose gout, pseudo-gout
- Diagnose and treat mild rheumatoid arthritis
- Diagnose and treat inflammatory arthritic diseases
- Diagnose and treat uncomplicated collagen diseases
- Diagnose and treat degenerative joint disease

Urology/Nephrology:

- Diagnose and treat initial and recurrent urinary tract infections including pyelonephritis
- Provide long term chemoprophylaxis for recurrent UTI
- Diagnose and treat urethritis
- Evaluate and treat hematospermia
- Evaluate hematuria
- Evaluate incontinence
- Diagnose and treat epididymitis and prostatitis
- Differentiate scrotal or peritesticular masses from testicular masses
- Evaluate prostatism and prostatic nodules
- Initiate evaluation of urinary stones
- Evaluate and manage impotence
- Evaluate and manage BPH

Vascular:

- Evaluate and treat varicose veins
- Evaluate peripheral vascular disease
- Evaluate carotid bruits
- Diagnose transient ischemic attacks

- Manage intermittent claudication
- Diagnose abdominal aortic/thoracic aneurysm

If the PCP wishes to refer the Member to a specialist, prior authorization must be obtained from the delegated PPG or Blue Shield Promise Health Plan if the provider is directly contracted (with the exception of self-referable services as outlined in the self-referable section under Utilization Management).

7.4: Authorization and Review Process

7.4.1: Authorization Time Frames

Inpatient and outpatient referral requests for Blue Shield Promise Health Plan members that are received from primary care and specialty care physicians will be processed according to classified status within the following designated time frames.

Emergency Post-Stabilization Services - Within **30 minutes** of verbal request.

Emergency care: Requires no prior authorization

Urgent - Within **72 hours** from the time they are received in the UM Department.

Urgent referrals received by telephone will be directed to a Case Manager or to the CMO when mandated, in order to make an immediate decision. The provider will be instructed to follow-up with a faxed copy of the request at a later time.

Urgent referrals are immediately forwarded for processing. The requesting provider's office will be contacted telephonically at the time of the determination informing them of the authorization decision for the requested service. Providers and Members will be sent written confirmation of the determination within two (2) calendar days.

Utilization Management Timeliness Standards

(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request.	Within 5 working days of receipt of all information reasonably necessary to render a decision.	Practitioner: Within 24 hours of the decision. Member: None Specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed (AKA: Deferral).	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request. • The decision may be deferred, and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan / Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. • Notify Member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to ren- der the decision, the type of expert reviewed, and/ or the additional examinations or tests required and the anticipated date on which a decision will be rendered.	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
	Additional information received • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service. **Additional information incomplete or not received** • If after 28 calendar days from the receipt of the re- quest for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the Member notice of denial.	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the re- quest for service. Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the re- quest for service.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request.	Within 72 hours of receipt of the request.	Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • Additional clinical information required.	Additional clinical information required: Upon the expiration of the 72 hours or as soon as you be- come aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and Member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/ or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. • Note: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group / Health Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. **Additional information received** If requested information is received, decision must be made within 1 working day of receipt of information. **Additional information incomplete or not received** Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision. Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Concurrent review of treatment regimen already in place– (i.e., inpatient, on-going/ ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of Member's medical condition. **NOTE:** When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision- making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. **CA H&SC 1367.01 (h)(2)**	Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Concurrent review of treatment regimen already in place– (i.e., inpatient, on-going/ ambulatory services). **OPTIONAL:** Health Plans that are NCQA accredited for Medi-Cal may choose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Member & Practitioner: Within 24 hours of receipt of the request. **Note:** If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification.
Post-Service/ Retrospective Review- All necessary information received at time of request (decision and notification are required within 30 calendar days from request).	Within 30 calendar days from receipt or request.	Member & Practitioner: None specified.	Member &Practitioner: Within 30 calendar days of receipt of the request.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Post-Service - Extension Needed • Additional clinical information required.	**Additional clinical information required (AKA: deferral).** • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request. **Additional information received** • If requested information is received, decision must be made within 30 calendar days of receipt of information Example: Total of X + 30 where X = number of days it takes to receive requested information. **Additional information incomplete or not received** • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information.	Member & Practitioner: None specified. Member & Practitioner: None required	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination. Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination.
Hospice - Inpatient Care	**Within 24 hours of receipt of request.**	Practitioner: Within 24 hours of making the decision. Member: None Specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.

Expedited Appeals – Refer to SECTION 6: GRIEVANCES and APPEALS, Section 6.2.1: Expedited Appeal

7.4.2: Authorization Validity

Authorizations are generally approved for 90 days with a disclaimer stating that authorizations are valid only if the Member is eligible on the actual date of service. Due to the fact that Member eligibility is on a month-to-month basis, Blue Shield of California Promise Health Plan providers must verify Member eligibility prior to delivery of non-emergency services. Eligibility can be verified for most members 24 hours a day, seven (7) days a week by calling Blue Shield Promise Health Plan Member Services at (800) 605-2556 (TTY (800) 735-2929). Providers are responsible for re-verifying eligibility and obtaining an updated authorization once it has expired.

7.4.3: Specialty Referrals

PCPs are responsible for providing all routine health care services, including preventive care, to their enrolled Members. However, Blue Shield Promise Health Plan recognizes that many times Members may require care that must be rendered by qualified specialists.

When, in the opinion of the PCP a Member referral to a specialist is indicated, a request shall be submitted to the Member's assigned PPG's UM Department for review and authorization. Treatment requests for Members assigned to Blue Shield Promise Health Plan Direct are to be faxed to the Blue Shield Promise Health Plan UM Department with the exception of services established as no prior authorization required under the direct referral process. Please refer to the Physician Direct Referral Form for a listing of services.

The following information must be provided in order to process the pre- authorization request:

- Working diagnosis
- PCP evaluation to date
- Treatments performed to date
- Clinical justification for the referral request
- Any other relevant medical history

Urgent requests may be received via fax or telephone. If a request is received via telephone, it is to be followed by a fax.

The PCP's office shall maintain a log indicating the Member information, date of request, type of specialist, clinical reason for referral and the authorization number. The specialist is required to send a completed consultation report to the PCP.

After review of the consultation results and recommendations, the PCP may request additional treatment authorization if clinically indicated. Contracted specialists also have the option to request additional treatment/care directly from the UM Department, providing the specialist forward the consultation/ follow up care and treatment results to the Member's PCP to be added as part of the Member's medical record.

7.4.4: Ancillary Referrals

PCPs are responsible for providing total coordination of all routine healthcare services, including use of ancillary services, for their enrolled Members. Therefore, all requests for Member referrals for ancillary services are submitted to the UM Department for review and authorization, with the exception of routine diagnostic laboratory tests through Quest Diagnostics and/or those required under the Quality Management preventive care requirements. Ancillary services are defined as those medical services provided by non-physician or mid-level professionals (i.e., PA's, NP's, etc.). This includes, but is not limited to, home care; physical, occupational, and speech therapies; diagnostic laboratory; x-ray; infusion services; and services provided by hospital-based outpatient departments, excluding ambulatory surgery, emergency room, and/or urgent care.

Ancillary services may be requested by a practitioner other than the Member's assigned PCP only if the requesting party is a participating physician to whom the Member has a current authorization by the UM Department for consultation and treatment.

7.4.5: Outpatient Services

Ambulatory services and outpatient surgery procedures require authorization by the UM Department. Providers can be held financially at risk for non-emergent services performed at their facilities without prior authorization. Services must be provided by the Member's PCP or the designated physician that has been given authorization by the UM Department for consultation and treatment. In the event that the service cannot be provided in network, an authorization will be conditionally approved by the Plan. Further information regarding out of network providers is covered subsequently in the manual.

The clinical staff will use clinically sound, medically appropriate criteria sets to evaluate necessity for outpatient and inpatient surgery. The ability to perform a surgery on an outpatient basis merely indicates that post-operative care does not require overnight stay in an acute care hospital. A facility authorization for routine outpatient surgery can be obtained through the Blue Shield Promise Health Plan UM Department.

PPGs are required to submit the approved PPG authorization requests to the UM Department prior to scheduling the procedures, with the exception of full risk PPG.

If an outpatient surgery of an acute hospital based ambulatory procedure is performed on an urgent/emergent basis, authorization will be obtained in the same manner as any urgent/emergent service.

When the authorization number is given, the caller will be advised that the number is for outpatient surgery only and that if the Member requires an inpatient admission status the Blue Shield Promise Health Plan UM Department must be notified.

When the Blue Shield Promise Health Plan UM Department is notified that a scheduled outpatient surgery has been converted to an inpatient status, a Case Manager will immediately implement the admission and concurrent review procedures.

7.4.6: Elective Admission Requests

All elective inpatient admissions require an authorization by the Blue Shield Promise Health Plan UM Department. Requests for elective inpatient admissions must be obtained from either the Member's PCP or from another physician/provider to whom the Member has current authorization from the UM Department for consultation and treatment. A request for an elective admission will be communicated to the Blue Shield Promise Health Plan UM Department by fax or telephone, as indicated by the urgency/timeliness of the request. Whenever possible, these requests should be made no less than five (5) business days prior to projected elective inpatient confinement.

If there is sufficient clinical information to determine that admission criteria are satisfied, the admission will be authorized. The Plan uses MCG Guidelines. Pre-determined lengths of stays are not assigned. Consideration has been given to the fact that each case may have different circumstances and that the recommended LOS serves as a guideline only.

Plan Notification: All contracted per-diem hospitals are responsible for notifying the Blue Shield Promise Health Plan UM Department of the inpatient admission by faxing the hospital admission sheets within 24 hours of admission, except for weekends and holidays.

7.5: Emergency Services and Admission Review

7.5.1: Emergency Services

"Emergency medical condition" Is defined as a medical condition manifesting itself by the sudden onset of symptoms of acute severity, which may include severe pain, such that a reasonable person would expect that the absence of immediate medical attention could result in placing the Member's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Emergency Care

Blue Shield Promise Health Plan Members are entitled to access emergency care without prior authorization. However, Blue Shield Promise Health Plan requires that when an enrollee is stabilized, but requires additional medically-necessary health care services, providers must notify Blue Shield Promise Health Plan prior to, or at least during, the time of rendering these services. Blue Shield Promise Health Plan wishes to assess the appropriateness of care and assure that this care is rendered in the proper venue.

Life Threatening or Disabling Emergency

Delivery of care for potentially life threatening or disabling emergencies should never be delayed for the purposes of determining eligibility or obtaining prior authorization. These functions should be delegated to a non-direct care giver at the emergency department (ED) to be done either concurrently with the provision of care or soon after as possible.

Business Hours

Blue Shield Promise Health Plan UM Department is available via telephone from 9:00a.m. to 6:00p.m., Monday thru Friday. In a 911 situation, if a Member is transported to an ED, the ED physician shall contact the Member's PCP (printed on the Member's enrollment card) as soon as possible (post stabilization) in order to give him/her the opportunity to direct or participate in the management of care. If the PCP intends to refer the Member to an ED, the PCP must call the ED to authorize the treatment. The physician's name, date, and time of the authorization will be documented in the ED medical record. If the Member seeks treatment at an ED without prior approval from the PCP, the ED will triage the Member and call the PCP for approval to treat the Member. It is the responsibility of the PCP to grant the authorization for treatment under these circumstances.

Medical Screening Exam

Hospital emergency departments under Federal and State Laws are mandated to perform a medical screening exam (MSE) on all Members p resented to the ED. Emergency services include additional screening examination and evaluation needed to determine if a psychiatric emergency medical condition exists. Blue Shield Promise Health Plan will cover emergency services necessary to screen and stabilize Members without prior authorization in cases where a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

After Business Hours

After regular Blue Shield Promise Health Plan business hours, Member eligibility is obtained and notification is made by calling the 800 number on the Member ID card. The 800 number connects to a 24-hour multilingual information service, which is available to Members as well as to providers. For information other than eligibility requests, the call service will cross connect the caller to a Blue

Shield Promise Health Plan On-Call nurse Case Manager. **THIS IS NOT A MEDICAL ADVICE SERVICE**. This service is for informational purposes and to coordinate Member care. In the event that a Member calls for advice relating to a clinical condition that they are experiencing and believe based on their perception that it is urgent/emergent, the Member will be advised to go to the nearest emergency room or to call 911.

The following are some of the key services that the on-call Case Managers will provide:

- Issue urgent/emergent treatment authorization numbers to providers.
- Act as a liaison to PCPs, specialists, and other providers to ensure timely access and the coordination of follow-up care for the Member's post emergency care.
- Facilitate Member transfers from emergency departments to contracted hospitals or California Children Services (CCS) paneled facilities when applicable.
- Arrange facility transfer ambulance transport services.
- Assist Members with non-emergent transportation services for weekend appointments when needed.
- Provide network resource information to Members and providers.
- Assist in pharmacy issues.
- Link Blue Shield Promise Health Plan contracted physicians to ED physicians when necessary.

For additional support the on-call nurse has access to the covering physician, or an alternate covering physician, to assist in physician related issues. Upon receipt for a request for authorization from an emergency provider, a decision will be rendered by Blue Shield Promise Health Plan within 30 minutes, or the request will be deemed as approved. If assistance is necessary for directing or obtaining authorization for care after the immediate emergency is stabilized, the on-call nurse will assist as the liaison to PCPs, specialists, and all other providers to ensure timely access and the effective coordination of all medically necessary care for the Member.

7.5.2: Urgent/Emergent Admissions

Prior authorization is not required for emergency admissions (see Emergency Services for definition of "emergency"). However, authorization should be attempted for urgent admissions. If the admitting physician is not the Member's PCP, the PCP should be contacted prior to admission when possible.

PCP Notification

The Member's PCP is to be contacted, if at all possible, prior to urgent/emergent hospital admission to discuss medical appropriateness and routing of the admission. Upon contact, the PCP will discuss the Member's case with the ED physician. If the case meets admission criteria, the PCP will authorize the admission under his/her care or opt to call in another physician of his/her choice. If the Member is in a non-contracted hospital, the PCP at that time may determine if the Member is medically stable for transfer to a contracted facility.

Plan Notification

All contracted per-diem hospitals are responsible to notify inpatient admissions to the Blue Shield Promise Health Plan UM Department by faxing the hospital admission (face) sheets within 24 hours of admission, except for weekends and holidays. Upon receipt of the hospital admission sheet, the UM Department will record a tracking number on the hospital admission sheet and fax it back to the hospital.

If no admission notification is received from the hospital by the next business day (with exception of weekends and holidays), the authorization for admission and continued stay will then be based on the concurrent and/or retrospective review procedures.

7.5.3: Concurrent Review

Blue Shield Promise Health Plan provides for continual reassessment of all acute inpatient care. Other levels of care, such as partial day hospitalization or skilled nursing care may also require concurrent review at the discretion of Blue Shield Promise Health Plan. Review may be performed on-site or may be done telephonically. Authorization for payment of inpatient services is generally on a per diem basis. The authorization is given for the admission day and from then on, on a day to day basis contingent that the inpatient care day has been determined to satisfy criteria for that level of care for that day. This would include the professional services delivered to the inpatient on that day. Any exceptions to this (i.e., procedures, diagnostic studies, or professional services provided on an otherwise medically necessary inpatient day which do not appear to satisfy criteria) will require documented evidence to substantiate payment. The date of the first concurrent review will generally occur on the second hospital day. The benefit of this process is to identify further discharge planning needs the Member may have due to unforeseen complications and or circumstances.

Clinical information may be obtained from the admitting physician, the hospital chart, or the hospital Utilization Review (UR) Nurse. The Case Manager will compare the clinical presentation to pre-established criteria (MCG Guidelines). If the criteria are satisfied, an appropriate number of days will be authorized for that stay. If the Member remains an inpatient, further concurrent review will be performed daily. The number of hospital days and level of care authorized for elective admissions are variable and are based on the medical necessity for each day of the Member's stay. This is done through criteria sets and guidelines, provider recommendations, and the discretion of the Case Managers and the CMO.

7.5.4: Discharge Planning

The purpose of discharge planning is to identify, evaluate and coordinate the discharge planning needs of Blue Shield Promise Health Plan Members when hospitalized. Discharge planning will begin on the day of admission for unscheduled inpatient stays. The review process will include chart review, data collection, and review of the care plan by the attending physician and other Members of the healthcare team. For elective inpatient stays, special requirements may be identified prior to hospitalization and coordinated through the prior authorization process.

The goal of the discharge planning process is to follow the Members through the continuum of levels of care until the Member is returned to his/her previous living condition prior to hospitalization, when possible. This approach is performed to ensure continuity of care and optimum outcomes for Blue Shield Promise Health Plan Members.

Multiple factors are taken into consideration to effectively evaluate the Member's clinical and psychosocial status for discharge needs. This includes the active problem, clinical findings, the Member's past medical history and social circumstances, and the treatment plan.

If the PCP was not the Attending Physician of the Member while hospitalized, all efforts will be made to notify him/her of any arrangements made for the Member.

This may be done by one of the following mechanisms:

- Dictated hospital summary note from the Attending Physician.
- Phone call from the Attending Physician.
- Phone call from the Blue Shield Promise Health Plan UM Case Manager.
- Inpatient Hospital Notification Form faxed by the Case Manager.

7.5.5: Retrospective Review

Blue Shield Promise Health Plan reserves the right to perform a retrospective review of care provided to a Member for any reason. There may also be times during the process of concurrent review (especially telephonic) that the Case Manager did not receive sufficient information based on criteria (MCG Guidelines). When this occurs, the case will be pended for a full medical record review by the CMO.

All retrospective review referrals are to be turned around within 30 working days of obtaining all necessary information. Notification of retrospective-review denials will be in writing to the Member and the provider.

When a retrospective UM review indicates that there has been an inappropriate provision of care, the case will be referred to the Quality Management Department for further investigative review and follow-up.

7.6: Authorization Denials, Deferrals and Modifications

A denial, deferral, and/or modification of a treatment authorization request may occur so that more information can be obtained or a recommendation of alternative care may be made during the authorization process. Other than the Member is not eligible, only physicians will make denial of service determinations. The signature of the Chief Medical Officer (CMO) or the reviewing physician is required on the denied referral request authorization form.

At the request of the Primary Care Physician (PCP), providing physician, Member or Member representative, such decisions may be referred for reconsideration or appeal for additional review and determination.

Blue Shield Promise Health Plan will send written notification of an authorization request denial, deferral, and/or modification to the Member, the Member's PCP, and/or Attending Physicians according to the provisions below:

- The PCP and/or the requesting provider will be sent a written or electronic confirmation within two (2) working days of the determination.
- The communication to the provider shall include the name and telephone number of the health care professional responsible. The rational is to afford the provider the opportunity to discuss the denial determination with him/her if the denial was based on medical necessity.
- The Member will be sent written confirmation within 48 hours of the determination.
- For concurrent care within 24 hours of the original notification, electronic or written.
- A disclosure of the specific utilization review criteria/guideline or benefit provision used as a basis for the denial will be sent to the Member and the provider.
- The disclosure shall be accompanied by the following notice: "The guidelines that were used by Blue Shield Promise Health Plan for your case are used by the Plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need."
- Criteria/guidelines will be made available upon request to the public, provider, or Member via phone request to the UM Department at (800) 468-9935, via fax to the UM Department at (800) 889-6577, or request via mail to UM Department at Blue Shield Promise Health Plan, 601 Potrero Grande Drive, Monterey Park, CA 91755.

The written notification shall include the following elements:

- The notice to the Member will inform the Member that he/she may file an appeal concerning the determination using the appeal process (as proscribed by the statute), prior to or concurrent with the initiation of a State Fair Hearing process.
- How to initiate an expedited appeal at the time they are notified of the denial.

- The Member's right to, and method for obtaining, a State Fair Hearing.
- The Member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel or another spokesperson.
- The name and address of the entity making the determination.
- The State's toll-free telephone number for obtaining information on legal service organizations for representation.
- The Department of Corporation's toll-free telephone number to receive complaints regarding a grievance against the Plan that has not been satisfactorily resolved by the Plan to the Member's satisfaction.

Included within the denial letter to Members and providers are the reasons for the denial determination and, if possible, alternative treatments or care.

No authorization shall be rescinded or modified after the provider renders the health care service in good faith for any reasons including, but not limited to subsequent rescissions, cancellations, or modification of the Member's contract or when the Plan did not make an accurate determination of the Member's eligibility.

7.7: Referrals

7.7.1: Second Opinion

The Member, the PCP, or a participating health professional that is treating an enrollee may on occasion request a second opinion prior to surgery to evaluate treatment options, assist with a diagnosis, or validate the need for specific procedures. The CMO will evaluate the medical necessity of an authorization referral request that is submitted formally for a second opinion consultation. An expert panel list is maintained and utilized or second opinion consultation referrals consisting of a board-certified specialist in each area of medicine.

Second opinions **when medically necessary** will be done by an "appropriately qualified healthcare professional" not previously involved in the Member's treatment plan.

"Appropriately qualified health care professional" is defined as a Primary Care Physician or specialist acting within his or her scope of practice, and with a clinical background including training and expertise related to the condition associated with the second opinion request.

Second opinion referral requests will be processed within a standard time frame based on the status of the request. When the Member's condition is such that the Member faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function or timeliness that would be detrimental to the Member's ability to regain maximum function, the second opinion determination shall be rendered as followed:

- **Urgent** - Within 72 hours
- **Routine** - Within 5 working days

Reasons for a second opinion shall include, but not limited to, the following:

- If the Member questions the reasonableness or necessity of a recommended surgical procedure.
- If the Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including (but not limited to) a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the Member requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

7.7.2: Self-Referable Services (Medi-Cal)

Blue Shield Promise Health Plan Medi-Cal Members have freedom of choice in obtaining certain specified services such as family planning, HIV testing, and care for sexually transmitted diseases (STDs). These services are self-referable both in-network and out-of- network. If the Member chooses to self- refer to any willing provider, including out-of-network providers, these services will be covered without pre-authorization.

The following list includes services that, when performed by the PCP, will be covered without prior authorization.

DESCRIPTION
Family Planning
Sexually Transmitted Diseases (STDs) Treatment
Abortion Services
Sensitive Services for Minors (12 yrs. of age and older if sexually active)
HIV Testing

Blue Shield Promise Health Plan maintains a list of preferred providers for highly specialized tertiary level care. All reasonable attempts will be made to route non-network care to these providers when applicable.

In most cases, payment for self-referable out-of-network services will be limited to the Medi-Cal fee schedule. As necessary, please refer to the State published document (MMCD Letter No. 94-13) on family planning and STDs. A copy of the document will be furnished to Blue Shield Promise providers upon request.

7.7.3: Direct OB/GYN Access

Blue Shield Promise Health Plan Members have the option to seek obstetrical and gynecological (OB/GYN) physician visits directly from an obstetrician and gynecologist or directly from a family practice physician providing obstetrical and gynecological services without prior approval from another physician, another provider, or the health care plan on an unlimited basis, as defined under the evidence of coverage in the Member Handbook.

Blue Shield Promise Health Plan's policy is to use contracted/participating providers, as well as medical necessity utilization protocols for any OB/GYN services rendered to a Member by a participating physician. The OB/GYN will be required to communicate to the Member's PCP all pertinent medical information that has occurred from such an encounter in order to maintain the continuity of care for that Member. An outline of the required provisions is as followed:

1. Referrals must be made to Blue Shield Promise Health Plan contracted OB/GYN physicians only.
2. Routine and preventive health care services including breast exams, mammograms, and pap tests.

3. Payment for the level of the consultation/follow-up that is indicated on the claim shall be established from the documentation sent along with the claim to substantiate the medical necessity for payment at that level.
4. Any recommended treatments, procedures or surgeries will require prior authorization.
5. Any OB/GYN who is also a PCP will be able to self-refer directly for OB services. Further treatments, procedures, or surgeries will require prior authorization from the Blue Shield Promise Health Plan UM Department.
6. Any OB/GYN who is a PCP will provide all GYN services, other than prior authorized surgeries and procedures included under the capitated primary care services payment agreement contract.

7.7.4: Independent Medical Review

The independent medical review (IMR) is an expansion of the appeal process; refer to SECTION 6: GRIEVANCE, APPEALS and DISPUTES, Section 6.3.

7.7.5: Continuity of Care

Blue Shield Promise Health Plan will ensure that a Member with the following conditions can request to remain with a terminated/non-contracted provider until a safe transfer to a Plan provider can be made, and it is consistent with good medical practice.

1. Acute Condition
2. Serious Chronic Condition
3. Pregnancy
4. Terminal Illness
5. The care of a newborn child between birth and age 36 months
6. Performance of a surgery or other procedure that is authorized by the plan

Definitions

"Continuity of care" Is ensuring that a Member's care is appropriately managed as the Member moves through the health care delivery system, follow up care is provided, and the Member's medical records and history follows the Member from provider to provider.

"Delegated" Defers responsibility for the activity as defined by contractual agreement.

"Terminated provider" Is a provider/physician whose contract to provide services to Plan Members is terminated or not renewed by the Plan or one of the Plan's contracting provider groups.

"Acute condition" Is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

"Serious chronic condition" Is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following:

1. Persists without full cure or worsens over an extended period of time.
2. Requires ongoing treatment to maintain remission or prevent deterioration

Procedure

1. Members may file requests with the Plan/ PPG for continuity of care when they are SPD members, newly enrolled converting from Medi-Cal Fee for Service via telephone, facsimile, or by mail.
2. Continuity of care considerations will be made in accordance with the urgency of the Member's condition at the time of such a request.
3. Continuity of care considerations are applicable only to those circumstances when the Member has an acute or serious chronic condition, high risk or late term pregnancy, terminal illness, care of a newborn up to 36 months, and/or performance of a surgery or other procedure that is authorized by the plan.
4. The timeframe for Members undergoing continued care with a terminated or non- contracted provider is up to 12 months. This timeframe may be extended in order for the Member's care to be transferred safely.
5. If the provider was contracted with the Plan/ PPG and the contract was terminated, the fee will be based on the contractual agreement prior to the termination.
6. If it is a non-contracted provider and there is no agreement between the Plan and the provider, then the Plan/PPG shall pay the provider similar rates as those paid to similar providers for similar services within a similar geographical region.
7. If the provider does not accept the payment rate, then the Plan/PPG is not obligated to continue care with the provider.
8. The provider shall be bound to the Plan's contractual requirements for quality assurance, utilization review and credentialing.
9. The Plan will monitor the care provided by requiring the provider to submit ongoing treatment plans, progress notes and other appropriate medical record information.
10. The Plan will coordinate the exchange of the Member's medical record information from the non-contracted/terminated provider to the Plan provider when the Member's condition allows for such a transition.

7.7.6: Reconstructive Surgery

Reconstructive surgery, as defined below, is a covered benefit for Blue Shield Promise Health Plan Members; however, coverage for cosmetic surgery as defined is excluded.

Definitions

"Reconstructive surgery" Is defined as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, tumors, infections, trauma, or disease to do either of the following:

1. Improve function
2. Create a normal appearance, to the extent possible

"Cosmetic surgery" Is defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

A procedure might be considered either cosmetic or medical depending on the reason for it (e.g. breast reduction surgery for pain).

Requests for reconstructive surgery for Members to correct a condition which has resulted in a functional defect or has resulted from injury or surgery and has produced a major effect on the Member's appearance will generally require review by the Chief Medical Officer (CMO) or a physician reviewer.

Submitted documentation of medical necessity should include all of the following:

1. Brief medical history
2. Condition being corrected
3. Date of injury (if applicable)
4. Symptoms
5. Length of time symptoms were present
6. Previous treatment attempted
7. Applicable operative reports
8. Applicable photographs

Physician Reviewer Evaluation

The reviewing physician may forward the case to a Blue Shield Promise Health Plan specialty advisor for evaluation and determination.

7.7.7: Standing Referral

Blue Shield Promise Health Plan Members that require ongoing extended access to specialty care for chronic, disabling, life threatening or degenerative conditions will qualify for the standing referral policy. The policy applies to those circumstances where the coordination of the specialty care for such a condition has become the principle care for the Member.

A request for a standing referral to a specialist may be initiated by the Member, the PCP, or the Specialty Care Physician (SCP), when the Member has a chronic, disabling, life threatening or degenerative condition requiring extended access for continued treatment and care, and it has been deemed necessary by Blue Shield Promise Health Plan.

Provisions for Requesting a Standing Referral

1. Request is made by the Member's PCP, SCP, or the Member.
2. Request is to be made to a Blue Shield Promise Health Plan contracted Specialist.
3. Request will be reviewed and agreed to between the PCP and SCP and submitted to the Plan or delegated medical group.

Standing referral requests will include:

1. Member diagnosis
2. Required treatment
3. Requested frequency and time period
4. Relevant medical records

Provisions for Requesting Extended Access to a Specialist

1. Request is made by the Member's PCP or Specialist.
2. Request is related to a life threatening or degenerative condition, or there are disabling factors involved in the request.
3. Request will be reviewed and agreed to by both the PCP and Specialist and submitted to the plan or delegated Medical Group.
4. Requesting PCP or Specialist will indicate the health care services the Specialist will be managing and detail those that will be managed by the PCP.

Review and Determination

1. Requests are reviewed by the CMO or medical director designee.
2. Determination will be provided within two (2) business days of receiving all necessary records and information.
3. Communication of the determination to the Member and involved practitioners will be provided within two (2) business days of receiving necessary records and information.
4. Approvals shall include:
   a. Number of visits approved.
   b. Time period for which the approval will be made.
   c. Extension request process.
   d. Standard reporting required from the Specialist to the PCP and /or the Plan delegated group physician reviewer.
   e. Process for requesting further referrals, if needed.
   f. Clause specifying: "… Member eligibility is to be determined at the time services are provided…"

Specialist Communication Guidelines to Primary Care Provider

1. Specialist will provide information to the PCP on the progress and or any significant changes in the Member's condition.
2. PCP will maintain all communicated information in the Member's medical record

7.8: Carve-Out Benefits: Public Health, Linked Services and Special Benefit Information

7.8.1: California Children Services ("CCS")

California Children's Services (CCS) are carved out of the Blue Shield Promise Health Plan benefit agreement. The CCS Program provides physical habilitation and rehabilitation for children with specified handicapping conditions through CCS certified providers. The program goal is to obtain the medical and allied services necessary to achieve maximum physical and social function for handicapped children. Identified children with CCS eligible conditions are referred to CCS immediately upon identification.

The Blue Shield Promise Health Plan UM Department can serve as a link between Blue Shield Promise Health Plan PCPs and the CCS Program. This will be done by appropriately identifying and channeling all potential/applicable referrals to CCS in accordance with the specified program standards.

7.8.2: Child Health and Disability Prevention Program ("CHDP")

All Members under 21years of age are to have access to and receive Child Health and Disability Prevention ("CHDP") Program services in accordance with state and federal requirements for providing preventive services to children.

The provision of CHDP services is accomplished through Blue Shield Promise Health Plan providers and/or local health department and school-based programs in accordance with L.A. Care's Memoranda of understanding.

All Members under 21 years of age are to receive an Initial Health Assessment within 120 days of enrollment. An IHA consists of a comprehensive health history and physical examination and includes an age appropriate health education behavioral assessment.

Comprehensive Health History and Physical Examination

CHDP standards include screening and immunization schedules for specific age groups. The CHDP health screening also includes a comprehensive health history that collects information on the following areas:

• Social/Cultural	• Allergies
• Environment	• Illnesses
• Family Health	• Accident
• Prenatal, Birth, Neonatal Development	• Hospitalizations
• Physical Growth	• Immunizations*
• Nutrition	• Communicable Diseases

The physical examination must be given while the Member is unclothed. Attention, therefore, should be given to the age of the Member and his/ her need for privacy.

The physical examination must include, but is not limited to:

Skin	Heart
Spine	Hair
Head	Abdomen
Eyes (Vision Testing)	*Genitals (pelvic exam)*
Ears (Audiometry)	*Extremities
Nose, Throat	Palpation of femoral,
Mouth, Gums,	Dental
Screen Brachial and radial pulse	Blood Pressure
Neck	Height and Weight Chest
Head Circumference	Lungs

*according to periodicity schedules

Tests are to include the following:

- Lead screening (lead level checks at ages 12 mon, 24 mon, or 72 mon with lead level range above 15 are to be referred to the Los Angeles Lead Program. Follow up lead re- check is to be done after 3 months on lead levels between 10-14 and/or confirmatory re-check to be done within 1-2 months on levels between 15-19)
- Tuberculin tests
- Cholesterol screening
- STD screening
- Lab testing for anemia, diabetes, and/or urinary tract infection
- Testing for Sickle Cell Trait

Follow-Up on Conditions Identified During CHDP Exams

Blue Shield Promise Health Plan will arrange for any medically necessary services identified through a health assessment (or episodic ex am). Treatment for these conditions is to be initiated within 60 days after identified need. (Medical records must contain a just then the Primary Care Physicians will coordinate continued medical care with the CHDP office.7.8.3: Regional Centers

Regional centers provide overall case coordination for eligible consumers and their families to assure access to health, developmental, social, educational and vocational services. Services are provided on a case by case basis, taking into consideration the availability of generic services appropriate to the consumer's needs.

Blue Shield Promise Health Plan Members who appear to qualify for regional center services will be appropriately identified and referred in accordance with the specifications of the Regional Center Program. This applies to the following:

1. Persons three (3) years of age and older with or suspected to have a developmental disability.
2. Persons from birth to 36 months who are at risk of developing a developmental disability.
3. Persons at risk of parenting a child with a developmental disability (genetic).
4. Individuals with a medical diagnosis which includes:
   - Mental retardation
   - Epilepsy
   - Autism
   - Cerebral Palsy

Other handicapping conditions closely related to mental retardation and requiring treatment similar to that required by persons with mental retardation.

Other applicable factors are that the condition:

- Must manifest prior to age 18
- Is likely to continue indefinitely
- Constitutes a substantial handicap

Factors that do ***not*** apply:

- Solely psychiatric disorders
- Solely learning disabilities
- Solely physical in nature (i.e. hearing impairment, vision impairment, orthopedic, etc.)

7.8.3: Early Prevention, Screening, Diagnosis and Treatment

Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services (ESS) are any services a state is permitted to cover under Medicaid law that are medically necessary to correct or ameliorate a defect, physical and mental illness or condition for a Member under the age of 21, if the service or item is not otherwise included in the State's Medi-Cal Plan.

EPSDT Services

- Case management services
- Cochlear implants
- Home nursing
- Psychology
- Occupational therapy
- Audiology
- Orthodontics
- DME (in certain instances)
- Hearing aids
- Mental health evaluation and services
- Medical nutrition services assessment and therapy
- Pharmacy
- Physical therapy evolution and services
- Pulse oximeters
- Speech therapy

Requested EPSDT services must meet the following medical necessity criteria:

- The services requested meet specific requirements for orthodontic dental services or provision of hearing aids or other hearing services.
- The services requested are to correct or ameliorate a defect, or physical or mental illness, discovered by an EPSDT screening.
- The supplies, items and/or equipment requested are medical in nature.
- The services requested are not solely for the convenience of the Member, the family, the physician or any other provider of service.
- The services requested are not primarily cosmetic in nature or designed to primarily improve the Member's appearance.
- The services requested are safe and are not experimental and are recognized as an accepted modality of medical practice.
- The services requested, when compared with alternatively acceptable and available modes of treatment, are the most cost effective.
- The services requested are within the authorized scope of practice of the provider and are an appropriate mode of treatment for the medical condition of the Member.
- The service requested improves the overall health outcome as much as, or more than, the established alternatives.

- The predicted beneficial outcome outweighs the potential harmful effects.
- Medi-Cal covers all medically necessary behavioral health treatment (BHT) for eligible beneficiaries under 21 years of age. This may include children with autism spectrum disorder (ASD) as well as children for whom a physician or psychologist determines it is medically necessary. Consistent with state and federal requirements, a physician or a psychologist must recommend BHT services as medically necessary based on whether BHT services will correct or ameliorate any physical and/or behavioral conditions.
- BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction, and promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD.
- Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

As an exception, Blue Shield Promise Health Plan is not responsible for payment for services provided under CCS, or for case management services provided by a state-conducted referral provider such as a regional center.

7.8.4: Women, Infants and Children ("WIC") Program

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides temporary nutrition, education and assistance for needy woman, infants and children.

Supplemental foods are selected to meet specific nutritional needs of pregnant or breastfeeding women and young children by using WIC vouchers. WIC is a free service for Members who meet eligibility requirements.

All WIC eligible Blue Shield Promise Health Plan Members who are pregnant, breastfeeding, postpartum, infants and children will be referred to WIC.

Screening of Nutritional Needs and WIC Eligibility Identification and Referral

PCPs are to identify pregnant, breastfeeding, or postpartum women, and children under the age of five whom are eligible for WIC supplemental food services.

PCPs are to perform a nutritional assessment and hemoglobin or hematocrit laboratory tests; and assess for a history of frequent illness or a general poor state of health.

In the case of pregnant women, PCPs may refer Members to nutritionists for further assessment.

The PCP or nutritionist is to initiate the referral to WIC, if appropriate. Test results reported on the CPSP assessment tool for OB Members, or on the CHDP Form PM-160 for children, are to be provided to the WIC Program with all referrals.

The PCP must document the WIC referral in the Member's medical record.

7.8.5: Comprehensive Perinatal Services Program (CPSP)

Pregnancy and Postpartum Services

Pregnant Members are to be provided comprehensive, multidisciplinary pregnancy and postpartum services with case coordination including obstetrics, risk assessment/reassessments, health education, nutritional services, and psychosocial services in accordance with the standards of the American College of Obstetrics and Gynecology (ACOG), the Comprehensive Perinatal Services Program (CPSP) specifications of Title 22 of the California Code of Regulations, and the provisions set forth below. Screen for prenatal and postpartum mental health conditions and refer for mental health services as appropriate.

Case Coordination Elements

Case coordination is the responsibility of the OB physician, although care coordination may be delegated to a team Member who is accountable to the Obstetric Physician.

Components of Case Coordination

Case coordination includes all clinical aspects of care as well as record keeping and communication, as detailed below. Every part of the multidisciplinary system should support personal attention to the Member and interaction with the physician.

- Assessments (obstetrical, nutrition, health education, and psychosocial).
- A written, individualized care plan based on all assessments.
- Appropriate interventions/treatments provided according to the care plan and approved protocols.
- Continuous assessments of the Member's status and progress relative to care plan interventions, with appropriate revision of care plan when necessary.
- Case conference or other appropriate communication involving all team Members regarding each Member's care.
- Comprehensive record system where all information relating to Member care is documented and is available to all team Members.
- Screen for prenatal and postpartum mental health conditions and refer for mental health services as appropriate.

Multidisciplinary Conditions/Issues

Common pregnancy and postpartum conditions and issues for multidisciplinary team discussion/ action include areas of nutrition (N), psychosocial conditions and services (PS), or health education (HE) such as those listed below.

Pregnancy Conditions/Issues

- Unintended or unwanted pregnancy (PS)
- Teenage pregnancy (PS)
- Housing and transportation problems (PS)
- Fear of physicians, hospitals, and medical personnel (HE)
- Language barriers (HE)
- Lack of basic reproductive awareness (HE)
- No previous contact with health care systems (HE)
- Previous receipt of unfriendly health care services (HE)
- Personal and religious beliefs at odds with optimal prenatal care (HE)
- Need for bed rest during pregnancy (PS), (HE)
- Multiple gestation (HE), (PS), (N)

Postpartum Conditions/Issues

- Postpartum blues, postpartum depression (PS)
- Housing, food, and transportation problems (PS)
- Lack of basic parenting skills and role models (HE)
- Breastfeeding difficulties (HE)
- Sexual pain/difficulties (HE)
- Severe anemia (N)

Conditions Requiring Medical Referrals

- Diabetes
- Hypertension
- Hepatitis
- HIV Infection
- Genetic Problems
- Epilepsy or Neurological Disorder
- Renal Disease
- Alcohol or Drug Abuse
- Maternal Cardiac Disorders
- Thyroid or Other Endocrine Disorders

Conditions/Issues Requiring Social Work Referrals

- Family Abuse
- Psychiatric Problems
- Chemical Abuse
- Financial Problems
- Insufficient home care resources/capabilities

Related Programs (e.g., CPSP, WIC, CHDP, family planning and dental services).

Providers are to inform Members of pregnancy and prenatal related programs and refer Members to them when appropriate.

7.8.6: Family Planning

Family planning includes the following services:

- Health education and counseling services necessary for Members to make informed choices and understand contraceptive methods.
- Limited history taking and physical examinations. PCPs or OB/GYNs are responsible for the comprehensive history taking and physical examinations.
- Laboratory tests, if medically indicated for the chosen contraceptive method. Pap smears, if not provided per USTF guidelines by PCPs or OB/GYNs.
- Diagnosis and treatment of sexually transmitted diseases, if medically indicated, pursuant to the sexually transmitted diseases section of this manual.
- Screening, testing, and counseling of individuals at-risk for HIV and referral for treatment for HIV-infected Members.
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Provision of contraceptive pills, devices, and supplies, as approved by Medi-Cal.

Providers will be required to obtain informed consent for all contraceptive devices.

- Tubal ligation
- Vasectomies
- Pregnancy testing and counseling

The stipulations below apply to the provision of family planning services:

1. Each physician/provider must be licensed in the state of California and have training/ experience in family planning.
2. A Medical Director who meets at least the above qualifications must oversee, if services are provided in a clinic setting, the clinic and all services provided there.
3. Informed consent must be obtained, in writing, from all Members for the provision of all-contraceptive devices and/or procedures. This consent will be filed in the Member's medical records.
4. In general, OB/GYN, family practice, or internal medicine physicians and nurse practitioners will provide family planning services to Members.

Members may receive care from:

- Their own Blue Shield Promise Health Plan PCP or OB/GYN
- A Blue Shield Promise Health Plan participating Family Planning provider
- Any out-of-plan Family Planning provider (This is limited to Medi-Cal Members only.)

7.8.7: Sensitive Services

"Sensitive services" Means those services that are defined as services related to sexual assault, sub stance or alcohol abuse, pregnancy, family planning, and sexually transmitted diseases for Members 12 years of age and older if sexually active.

Benefit Coverage

Members 12 years of age and older may sign an Authorization for Treatment form for any sensitive services (without parental consent). Parental or guardian consent is required for Members under 12 years of age who seek substance or alcohol abuse treatment services, or for treatment of sexually transmitted diseases.

The Member's PCP should encourage Members to use in-plan services to enhance coordination of care. However, Members may access sensitive services through out-of-network providers without prior authorization.

Family Planning (sensitive) services shall include, but not be limited to:

- Medical treatment and procedures defined as family planning services under current Medi-Cal scope of benefits
- Medical contraceptive services including diagnosis, treatment, supplies, and follow- up Informational and education services

In compliance with federal regulations, Blue Shield Promise Health Plan Members have free access to confidential family planning services from any family planning provider or agency without obtaining for these services. Access to sensitive services will be timely. Services to treat sexually transmitted diseases or referrals to substance and alcohol treatment are confidential.

Examples of Covered Services:

- Routine pregnancy testing
- Elective therapeutic abortions
- Birth control pills
- "Morning after pill" to avoid pregnancy is approved by the FDA for emergency treatment only (e.g., rape, incest, etc.)
- Depo-Provera as routine birth control
- Norplant, including device, insertion and removal
- Intra-uterine device (IUD) including device, insertion and removal
- Diaphragm
- Contraceptive foam, male and female condoms, cervical caps, sponges, etc.
- Elective tubal ligation
- Elective vasectomy

Office visits for education and instruction for birth control, including symptom- thermal method, billings method, rhythm method; and instruction and education regarding the methods and devices listed above.

- STD screening, testing, diagnosis, education, and referrals for treatment
- HIV screening, testing, diagnosis, education, and referrals for treatment

7.8.8: Sexually Transmitted Disease

Blue Shield Promise Health Plan will provide Members with confidential sexually transmitted disease (STD) screening and testing, diagnosis, treatment, follow-up, counseling, education and preventive care. Members should be encouraged to obtain these services from their PCPs. However, Members have the right to receive some services outside of the PCP without prior authorization.

STD Reporting

State law mandates that specified STDs be reported to local health departments. All diagnosed Members that fail to complete treatment must also be reported to the applicable local health department.

7.8.9: Mental Health (Medi-Cal Managed Care)

Inpatient and specialty outpatient mental health services are carved out of the Blue Shield Promise Health Plan Medi-Cal benefit agreement. Blue Shield Promise Health Plan Members may directly access specialty mental health services through the Department of Mental Health.

Behavioral Health Services Access

There are multiple entry paths for Blue Shield Promise Health Plan members to access behavioral health services. Referrals may be requested by primary care physicians (PCPs), specialty providers, County Departments, Community Based Organizations, case managers and member self- referrals. The Blue Shield Promise Health Plan contracted MBHO has a toll free 800 number that is available 24/7 for behavioral health service authorization requests. The MBHO number is listed on the member's ID card. Blue Shield Promise also has a toll free 800 number that is available 24/7 for general inquiries, member eligibility verification, business hour service authorization requests and after hour service authorization requests. After hour requests are coordinated by cross connecting callers to the afterhours Blue Shield Promise Health Plan on call nurses. The nurses have 24-hour access to Blue Shield Promise Health Plan physicians for assistance in making any medical necessity determinations that are beyond the nursing scope of practice. The after-hour nurse are educated and trained in coordinating behavioral health service referrals as for all levels of mental health treatment to the appropriate provider network for behavioral health care.

Medi-Cal Managed Care Plan Behavioral Health Benefits and Services

It is the responsibility of Blue Shield Promise Health Plan to provide Medi-Cal Managed Care Plan (MMCP) Behavioral Health Benefits for members defined by the current Diagnostic and Statistical Manual of Mental Disorders DSM resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning.

Role of Primary Care Physicians

The Primary Care Physician is responsible for:

- Initial Health Assessment and IHEBA using an age appropriate DHCS approved assessment tool
- Screening for Mental health Conditions
- Offer behavioral counseling intervention(s) to members that provider identifies as having risky or hazardous alcohol use, when a member responds affirmatively to the alcohol question in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified, in accordance with Alcohol Misuse Screening and Counseling (AMSC) protocols.
- Referrals for additional assessment and treatment

Primary Care Physicians appropriately provide significant amounts of mental health care that fall within their scope of practice, including the prescribing of psychotherapeutic drugs.

Blue Shield Promise Health Plan is responsible for outpatient behavioral health services for members defined by the current DSM resulting in mild to moderate distress or impairment of mental health, emotional, or behavioral functioning provided by Blue Shield Promise Health Plan contracted MBHO.

If the PCP determines that the members needs access to specialty mental health services, often evidenced by severe mental impairment, the PCP should refer directly to the county mental health plan.

Any member identified with possible alcohol use disorders shall be referred to the County Alcohol and Drug Program in the county where the member resides for evaluation and treatment.

MBHO Behavioral Health Services

Behavioral services will be provided by independent practice level licensed mental health care providers acting within the scope of their license. The services include:

1. Individual/group mental health evaluation and treatment (psychotherapy).
2. Psychological testing when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purpose of monitoring drug therapy.
4. Psychiatric consultation for medication management.
5. Outpatient laboratory, medications, supplies, and supplements.

7.8.10: Vision

Blue Shield Promise Health Plan Members are eligible to receive vision care services, including the provision of examinations and eyewear at the same location.

Blue Shield Promise Health Plan is contracted with a network of participating ophthalmologists, optometrists, hospital outpatient departments, and organized outpatient clinics strategically throughout Los Angeles County in order to provide enrolled Members with convenient access to vision care services. If the Member belongs to a contracted PPG, the PCP should submit the referral to the PPG. **Providers must use the Prison Industry Authority (PIA) Optical lab for all glass lens prescriptions.**

Participating vision care providers are authorized to submit claims for vision care services and appliances to Blue Shield Promise Health Plan, in accordance with Medi-Cal vision care policies and billing instructions.

Members may obtain, as a covered benefit, one pair of corrective lenses every two (2) years. Additional services and lenses are to be provided based on medical necessity.

If the optometrist for any reason feels the Member should be referred to an ophthalmologist or other physician, he/she is to call the Member's PCP for a telephone referral authorization. This is necessary to ensure the PCP is aware of any potential conditions that may be related to the general health of the Member (such as diabetes).

7.8.11: Dental

PCPs will conduct primary care dental screenings and facilitate appropriate and timely referrals to dental providers. Services delivered by dental providers are carved out of the Blue Shield Promise Health Plan benefit agreement.

PCPs shall perform an inspection of the teeth and gums for any signs of infection, abnormalities, malocclusion, and inflammation of gums, plaque deposits, caries or missing teeth. If any of the above conditions are observed, PCPs should instruct the Member to make an appointment to see a dentist. Blue Shield Promise Health Plan maintains a current list of Medi- Cal dental providers and will be available to assist PCPs in the dental referral process.

As part of the CHPD health assessment, children are to be referred to a Medi-Cal dentist if a dentist has not seen them within the prior six (6) months. Dental screenings of adults are accomplished, at a minimum, as part of the periodic examinations recommended by the United States Preventive Services Task Force (USPSTF) in addition to the course of other encounters. PCPs are encouraged to educate Members about the importance of dental care and to make corrective and preventive referrals.

PCPs are to document screenings and referrals in the Member's medical record.

7.8.12: Organ Transplant

Major organ transplants are excluded services. Members who are approved candidates for a transplant procedure will be disenrolled from the Plan and covered by fee-for-service Medi-Cal. All County Organized Health Systems (COHS) are capitated for major organ transplants for Members aged 21 years or older. For Blue Shield Promise Health Plan Members under 21 years of age, the responsibility for provision of and payment for major organ transplant procedures is covered under California Children's Services (CCS).

Blue Shield Promise Health Plan's goal is to achieve early identification of potential transplant candidates, and carefully coordinate services so that Members will have prompt access to the most experienced organ transplantation centers in California. Blue Shield Promise Health Plan, in collaboration with its provider network, will identify Members potentially requiring an organ transplant. Once identified, the Member will be referred to a tertiary transplant center to facilitate a work up in order to determine if the candidate is eligible for a transplant.

If the Member is deemed eligible he /she will be disenrolled from the Plan and be enrolled into fee- for-service Medi-Cal.

Approved Fee-For-Service Organ Transplantation

- Bone marrow transplants
- Heart transplants
- Lung and Heart-lung transplants
- Liver transplants
- Liver-kidney combined transplants
- Liver-small bowel combined transplants

Renal and Corneal Transplants

Renal and corneal transplants for Members aged 21 years and older are a covered benefit under Blue Shield Promise Health Plan. Upon identification of a Member in need of a renal or corneal transplant, Blue Shield Promise Health Plan will refer the Member to a DHS licensed and certified hospital with a renal transplant unit. Blue Shield Promise Health Plan is responsible for the continuation of all necessary primary care services and the provision of all services related to renal and corneal transplantation including, but not limited to, the evaluation of potential donors and harvesting of the organs from living or cadaver donors.

Blue Shield Promise Health Plan will refer Members under the age of 21 in need of evaluation as potential renal and corneal transplant candidates to the appropriate CCS Program office for referral to an approved CCS transplant center. All related transplant services shall be sent to the local CCS Program office for authorization.

7.8.13: Long Term Care

For Members that meet long-term care criteria, Blue Shield Promise Health Plan UM Department will authorize, when medically appropriate, the admission and continued stay to the LTC facility, rehabilitation facility, or intermediate-care facility.

7.8.14: Alcohol and Drug

Alcohol Misuse Screening and Behavioral Counseling (AMSC) (Formerly SBIRT)

It is the policy of Blue Shield Promise Health Plan to provide and pay for Alcohol Misuse Screening and Behavioral Counseling Interventions for members 18 years of age and older who misuse alcohol. The term "alcohol misuse" is used to define a spectrum of behaviors, including risky or hazardous alcohol use (e.g., harmful alcohol use and alcohol abuse or dependence). Risky or hazardous alcohol use means drinking more than a recommended daily, weekly, or per-occasion amounts resulting in increased risk for health consequences. Consistent with the Preventive Services Medi-Cal Provider Manual, PCPs must annually screen adult members 18 years of age and older for alcohol misuse. Although MCPs must provide one alcohol misuse screening per year, additional screenings must be provided when medically necessary. Medical necessity must be documented by the member's PCP.

Blue Shield Promise Health Plan considers the following three tools as the instruments of choice for screening for alcohol misuse in the primary care setting. Accordingly, MCPs must use one of these validated screening tools when screening members for alcohol misuse:

1. Identification Test (AUDIT);
2. The abbreviated AUDIT-Consumption (AUDIT-C); and
3. A single-question screening, such as asking, "How many times in the past year have you had 4 (for women and all adults older than 65 years) or 5 (for men) or more drinks in a day?"

Blue Shield Promise Health Plan must provide members with brief face-to-face behavioral counseling interventions, as specified by the Preventive Services Medi-Cal Provider Manual to reduce alcohol misuse when, during the screening process, a member is identified as being engaged in risky or hazardous drinking. PCPs must provide a minimum of three behavioral counseling interventions for alcohol misuse. Additional behavioral counseling interventions must be authorized when medically necessary. Medical necessity must be documented by the member's PCP.

PCPs must ensure that members who, upon screening and evaluation, meet the criteria for an Alcohol Use Disorder (AUD) as defined by the current DSM (DSM-5, or as amended), or whose diagnosis is uncertain, are referred for further evaluation and treatment to the county department for alcohol and substance use disorder treatment services, or a DHCS-certified treatment program.

PCPs must maintain documentation of the alcohol misuse screening of their members. When a member transfers from one PCP to another, the receiving PCP must obtain the member's prior medical records, including the IHEBA. If the IHEBA is not available, the new PCP must conduct and document an IHEBA that includes an alcohol misuse screening question.

7.8.15: Tuberculosis

Blue Shield Promise Health Plan and its providers will work in close coordination with the local health departments in the treatment and management of Blue Shield Promise Health Plan Members with tuberculosis (TB).

All efforts will be made to identify cases of tuberculosis among Members as early as possible, to render infectious cases of TB to non-infectious as rapidly as possible, and to prevent non- infectious cases from becoming infectious. This will be done in accordance with the Los Angeles County Department of Health Services TB Control Program's developed guidelines and policies for suspected TB cases.

PCPs will serve as the overall Case Managers for the screening and treatment of TB for Blue Shield Promise Health Plan Members. Blue Shield Promise Health Plan UM Case Managers will participate in a supportive role in coordinating, referring, reporting, contacting and the assessment of needs for any identified Member that is suspected of having or has TB.

7.8.16: Waiver Program

Waiver Programs provide services in the home for Members who are currently receiving care in acute or skilled nursing facilities. Members meeting criteria for waiver services will be referred to those programs. Blue Shield Promise Health Plan will efficiently arrange the Member's disenrollment and transfer of care to fee-for-service Medi-Cal, thereby enabling the Member to receive care appropriately and safely in a home environment rather than an institution.

Members suitable for the Medi-Cal Waiver Program are:

- Members who have been in a skilled nursing facility (SNF) beyond 30 days without improvement and unable to maintain self-care.
- Members in custodial care.
- Members with an AIDS diagnosis.
- Members with other factors as noted in specific waiver criteria.

7.8.17: Phenylketonuria (PKU)

The treatment and testing of PKU are covered benefits under the Medi-Cal Program. The benefit includes formula and special food products that are medically necessary for the treatment of PKU. The screening of PKU is provided through the Plan's contracted hospital after birth, but prior to discharge of the newborn.

Metabolic diseases may be a carve-out benefit and may be covered through California Children's Services (CCS). Infants and children up to the age of 21 years that are identified as having PKU will be referred by the Plan to CCS for case management.

Medically Necessary Enteral Nutrition Products

Plans are required to provide or arrange for all medically necessary covered services, and to ensure that these covered services are provided in an amount no less than what is offered to beneficiaries under Medi-Cal Fee-For-Service. Plans shall develop and implement written policies and procedures for providing medically necessary enteral nutrition products for outpatient Members that minimally meet the new Medi-Cal enteral nutrition benefit policy outlined in the Enteral Nutrition Products sections of the Medi-Cal Part 2 Pharmacy Provider Manual.

Requirements for Medical Authorization of Enteral Nutrition Products:

- A prescription by a licensed provider is required;
- Authorization procedures and review for approval of enteral nutrition products shall be supervised by qualified healthcare professionals;
- Decisions and appeals regarding enteral nutrition products shall be performed in a timely manner based on the sensitivity of medical conditions and rendered as:
    - Emergency requests: in no event shall prior authorization be required when there is a bona fide emergency requiring immediate treatment (W&I Code Section 14103.6);
    - Expedited requests: within three (3) working days for services that a provider or a Plan determines that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function;
    - Non-emergency requests: within five (5) working days when proposed treatment meets objective medical criteria, and is not contraindicated; and
    - A regimen already in place: within five (5) working days for review of a currently provided regimen as consistent with urgency of the Member's medical condition, as required by Health and Safety Code Section 1367.01;
- Any decision on enteral nutrition products that is delayed beyond these time periods is considered approved and must be immediately processed as such;
- Verbal or written notification shall be provided to any provider requesting a service by prior authorization that is denied, approved, or modified in an amount, duration or scope that is less than that requested by the provider;
- Members shall be notified about denied, deferred, or modified services; and
- Plans shall publicize the appeals procedure for both providers and Members.

Definitions

"Formula" Is defined as an enteral product for use at home.

"Special food products" Is defined as products that are specially formulated to have less than one gram of protein or used in place of normal food products such as grocery store foods used by the general population.

7.8.18: Cancer Screening

Cancer screening tests are covered benefits under the Medi-Cal Program. Blue Shield Promise Health Plan follows the standards established by the United States Preventative Services Task Force (USPSTF) as outlined under Section 9.5 of the Provider Manual. In addition, annual cervical screenings include the conventional Pap test and the option of any cervical cancer screening test approved by the FDA upon the referral of the Member's health care provider.

7.8.19: Cancer Clinical Trials

Blue Shield Promise Health Plan covers routine Member care services that are related to the clinical trial for a Member diagnosed with cancer and accepted into a phase I, phase II, or phase IV clinical trial for cancer. The clinical trial program's endpoint shall be defined to the test toxicity, and to have a therapeutic intent. The treatment shall be provided in a clinical trial that either (a) involves a drug that is exempt under federal regulations from a new drug application, or (b) is app roved by one of the following:

- One of the National Institutes of Health (NIH).
- The Food and Drug Administration (FDA) in the form of an investigation new drug application.
- The United States Department of Defense (DOD).
- The United States Veterans' Administration (VA).

7.8.20: AIDS Vaccine Coverage

In the event the FDA approves a vaccine for AIDS, it will be covered.

7.8.21: Services Under the End of Life Options Act (ABx2-15) for Medi-Cal Members

End of life services (EOL Services) under this Act, patient consultation by a physician and prescription of aid-in-dying medication, are carved out from Medi-Cal health plans like Blue Shield Promise Health Plan. Medi-Cal Fee-For-Service (FFS) will provide coverage and reimbursement for physicians who provide EOL Services.

Provision of these services by health care providers is voluntary. If you are a physician enrolled in the Medi-Cal FFS program, you may voluntarily provide Blue Shield Promise Health Plan Medi-Cal members with EOL Services under the Medi-Cal FFS services, not under your contract with Blue Shield Promise Health Plan, and seek payment for EOL consultations from the Medi-Cal FFS program.

You are responsible for documenting an oral request by a Blue Shield Promise Health Plan Medi-Cal member for EOL Services whether or not you volunteer to provide these services to the member.

7.9: Delegated UM Reporting Requirements (Participating Provider Group "PPG") Only

The purpose of UM reports is to provide ongoing monitoring for delegated UM functions and to ensure that services and decisions rendered by the delegated PPG are appropriate and meet DHS, DMHC, and Blue Shield Promise Health Plan standards. All delegated PPGs must report and submit UM information to Blue Shield Promise Health Plan as described below (See also Appendix 3: UM IPA Delegation Matrix) on a monthly, quarterly, and annual basis.

Monthly Reporting Requirements

Monthly reports are due to Blue Shield Promise Health Plan by the 15th of the month following the month in which services were rendered or denials made, and include the following:

1. Authorization Tracking Report –Include authorization #, Member name, requested date, approval date, diagnosis, and requested services.
2. Authorization Turn Around Time Report.
3. Denials and Modifications – Include all referral and denial/modification information and copies of all denial/modification letters.
4. Case Management Log – Include Member name, SSN#, diagnosis, PCP, intervention, and status of the case (open or closed).
5. Second Opinion Tracking Log – Include all authorizations, modifications, and denial.
6. information for second opinion requests. The log must include the reason the second opinion was requested.
7. Linked Services Logs – Include Member name, PCP name, diagnosis, and intervention.
8. HIV/ABR Reporting – Report to include CIN, Medi-Cal number, Blue Shield Promise Health Plan ID, PPG, Mo/Yr diagnosed, Mo/Yr billed, date last billed, Aid Code,

AEVS Verification number.

9. ESRD- Log to include authorization number and category, Member name, DOB and member ID; PCP, ICD9, CPT and description; requesting provider, referred provider and specialty, place of service and quantity; request type and date, decision and decision date.
10. Organ Transplant – Log to include Member name, diagnosis, review plan, date case opened and/or closed, monthly updates, and level.

Quarterly Reporting Requirements

1. UM quarterly reports must be submitted to Blue Shield Promise Health Plan 45 days after the end of the quarter (May 15th, August 15th, October 15th, February 15th) The report should include, at a minimum, UM activities, trending of utilization activities for under and over utilization, Member and provider satisfaction activities, and inter-rater reliability activities and improvement.
2. Continuity of Care/Out of Network reports are to be submitted by the 1st of the month following the end of the quarter (May 1st, August 1st, October 1st, February 1st) COC Include Total number of PCP/SCP termed, total number of members requesting assistance, and total number of members allowed continuing access to provider and total number of members whose coverage was ended while still needing care. OON include number of provider OON requests, approved, and in progress, and number of PPG referrals to OON providers.

Annual Reporting Requirements

The following reports must be submitted annually to Blue Shield Promise Health Plan by February 15th of each calendar year:

1. UM Program Description: Reassessment of the UM Program description must be done on an annual basis by the UM/ QM Committee.
2. UM Work Plan: Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The work plan should include planned audits, follow-up activities and interventions related to the identified problem areas.
3. UM Program Annual Evaluation: The evaluation should include a description, trending, analysis and evaluation of the overall effectiveness of the UM Program.

All reports must be submitted to Blue Shield Promise Health Plan within the timeframes specified. There must be separate reports generated for Medi-Cal and Healthy Families Members. Consistent failure to submit required reports may result in action that includes, but is not limited to, request for a corrective action plan (CAP), freezing of new Member enrollment, or termination of Blue Shield Promise Health Plan Agreement.

7.10: Managed Long-Term Support Services (MLTSS)

Blue Shield Promise Health Plan providers may refer a Member to the health plan for consideration to receive MLTSS. Each of these programs is subject to its own eligibility criteria, and a submitted referral does not necessarily guarantee approval of service (See Appendix 4).

MLTSS programs include:

1. Community Based Adult Services (CBAS) A community-based day health program that provides services designed to be an alternative to nursing home placement for Medi-Cal recipients that are 18 years of age or older with chronic medical, cognitive, or behavioral health conditions and/or disabilities. Services promote personal independence, address the individual's specific health and social needs in a safe, positive, and caring environment.
   Services provided at the center include:
   - Professional nursing services
   - Physical, occupational and speech therapies
   - Therapeutic activities
   - Social services
   - Personal care
   - Hot meals and nutritional counseling
   - Mental health services
   - Transportation to and from the participant's residence

2. In-Home Supportive Services (IHSS)
   A program that allows the enrollee to select their provider for in-home care if they cannot safely remain in their home without care giving assistance. To qualify for IHSS, the enrollee must be blind, disabled, 65 years of age or older and receive or be eligible to receive Supplemental Security Income/State Supplemental Payment or Medi-Cal benefits.
   IHSS authorized tasks include:
   - Housework
   - Meal preparation
   - Shopping
   - Personal Care Services
   - Paramedical Services
   - Accompaniment Services

3. Multipurpose Senior Services Program (MSSP)
   A California-specific case management program that provides Home and Community- Based Services (HCBS) to eligible Medi-Cal beneficiaries who are 65 years or older and are certifiable for placement in a nursing facility but wish to remain living in the community. Services include:
   - Case Management
   - Transportation
   - Chore Services
   - Protective Supervision
   - Personal Care Services
   - Money Management
   - Respite Care (in-home and out-of-home)
   - Environmental Accessibility Adaptations
   - Housing Assistance/ Minor Home Repair, etc.
   - Adult Day Care / Support Center / Health Care
   - Meal Services - Congregate / Home Delivered
   - Social Reassurance / Therapeutic Counseling
   - Communication Services: Translation / Interpretation
   - Personal Emergency Response System (PERS)/ Communication Device

4. Long-Term Care/Custodial Care
   Long-Term Care/Custodial care is the provision of medical, social and personal care services provided to Medi-Cal recipients who cannot live safely at-home but do not need to be in a hospital. Individuals are placed at the level of care most appropriate for their medical needs and include Skilled Nursing Facilities (SNF), Sub-Acute Facilities, and Intermediate Care Facilities.

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SECTION 8: ENCOUNTER DATA

8.1: Encounter Data- Medi-Cal

Policy and Procedures

Encounters include all services for which Medical Group is responsible. Medical Groups shall submit encounter data at least once monthly, but more frequently is preferred. Medical Group shall submit complete and accurate data in 837P, 837I & 837D formats using the national standard codes acceptable by Blue Shield of California Promise Health Plan within thirty (30) calendar days from the Date of Service ("DOS") in which care was rendered. The Medical Group must meet all data quality measurements established by Blue Shield Promise Health Plan and is responsible for correcting and re-submitting all rejections to Blue Shield Promise Health Plan within 10 days of notice received.

All encounters must be submitted electronically using the 837 5010 format. Standardized 5010 EDI Response files will be provided for all encounter files received.

Encounter Data submissions must meet all requirements outlined in the Companion Guides and are exchanged through the established secure server.

If you have encounter data submissions questions or if you would like to know how to submit using a clearinghouse, please email EDI_PHP@blueshieldca.com.

Providers who are contracted with Blue Shield Promise Health Plan through a delegated IPA/Medical Group must submit encounter data to their affiliated IPA/ Medical Group in the format and within the timeframes established by the IPA/Medical Group.

COMPLIANCE GUIDELINES

Volume of the Data

It is important to comply with encounter submission requirements and to report all services to meet established Encounter data quantity targets.

Quality of the Data

Data acceptance rate shall not be less than 95% of all data submitted. The Medical Group is responsible to correct the rejections and re-submit the corrections to Blue Shield Promise Health Plan within 10 days of notice received.

Timeliness of the Data

Encounter data shall be submitted to Blue Shield Promise Health Plan within thirty (30) calendar days from Date of Service ("DOS") in which care was rendered.

8.2: Encounter Data Contact Requirement

Blue Shield Promise Health Plan requires that anyone responsible for submitting encounter data provide primary and secondary contact information to Encounter_Ops@blueshieldca.com.

Contact information includes the following:

- Office telephone #
- Business cell #
- Fax #
- Email

SECTION 9: QUALITY IMPROVEMENT

9.1: Quality Improvement Program

Mission Statement

Blue Shield Promise Health Plan's Quality Improvement (QI) Department's mission is to provide an effective, system-wide plan and process for monitoring, evaluating and improving quality of care and services to members. We are committed to achieving high standards of medical care in a cost effective and efficient manner through an integrated organizational approach.

Purpose

The QI Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of care and services delivered to members. In addition, it provides mechanisms that allow us to continuously pursue opportunities for improvement and problem resolution.

Goals

- Ensuring members receive the highest quality of care and services.
- Ensuring members have full access to care and availability of primary care physicians and specialists.
- Monitoring, improving and measuring member and practitioner satisfaction with all aspects of the delivery system and network.
- Utilizing a multi-disciplinary approach to assess, monitor and improve policies and procedures.
- Promoting physician involvement in quality improvement program and activities.
- Fostering a supportive environment to help practitioners and providers improve the safety of their practices and adhere to all state and federal laws and regulations.
- Meeting the changing standards of the practice of the healthcare industry.
- Promoting the benefits of a managed care delivery system.
- Adopting, implementing and supporting ongoing adherence with NCQA Standards.
- Promoting preventive health services and case management of members with chronic conditions.
- Emphasizing a caring professional relationship between the patient, practitioner and health plan.
- Ensuring there is a separation between medical and financial decision making.
- Seeking out and identifying opportunities to improve the quality of care and services provided to members.
- Seeking out and identifying opportunities to improve the quality of services to practitioners.

Objectives

- Ensuring that timely, medically necessary and appropriate care and services that meet professionally recognized standards of practice are available to members.
- Ensure that quality care is given through the monitoring, investigating and resolving of problems. We focus on known or suspected issues that are revealed through tracking, trending and measuring specific clinical indicators, preventive health services, access to services and member satisfaction, using a total quality improvement philosophy.
- Systematically collecting, screening, identifying, evaluating information about the quality and appropriateness of clinical care and provide feedback to IPA/PMGs and practitioners about their performance and the network-wide performance.
- Maintaining a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity, and performance.
- Objectively and regularly evaluating professional practices and performance on a proactive, concurrent and retrospective basis through credentialing and peer review.
- Ensuring members are afforded accessible health care by continually assessing the access to care and availability of network of practitioners and specialists.
- Designing and developing data systems to support Quality Improvement monitoring and measurement activities.
- Assuring compliance with the requirements of accrediting and regulatory agencies including, but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Dedication of a full-time medical director whose responsibility is direct involvement in the implementation of the Quality Improvement activities in accordance with Title 22 CCR Section 53857.
- Appropriately oversight of Quality Improvement activities of our contracted IPA/PMGs.
- Striving to ensure that the Quality Improvement structure, staff and processes follow all regulatory and oversight requirements.
- Ensuring accountability through involvement of the governing body, designation of the Quality Management Committee (QMC) with oversight and performance responsibility, delegation of the Medical Director with supervision of Quality Improvement activities and inclusion, of contracting practitioners and providers in the Quality Improvement process and performance review.
- Establishing and conducting focused review studies, with an emphasis on preventive services, high-volume practitioners and services and high-risk services with implementation of processes to measure improvements.
- Actively working to maintain standards for quality of care and accessibility of care and service.
- Ensuring that mechanisms are in place to support and facilitate continuity of care within the healthcare network and to review the effectiveness of such mechanisms.
- Identifying potential risk management issues.
- Effectively interfacing with all interdisciplinary departments and practices for the coordination of quality Improvement activities.

- Providing a confidential mechanism of documentation, communication and reporting of Quality Improvement issues and activities to the Quality Management Committee (QMC), Board Quality Improvement Committee (BQIC), Compliance Department, and other appropriate involved parties.
- Assessing the effectiveness of the Quality Improvement Program and make modifications and enhancements on an ongoing and annual basis.
- Ensuring members have access to all available services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- Ensuring mechanisms are in place to identify, support and facilitate patient safety issues within the network and review the effectiveness of these mechanisms.
- Monitoring, evaluating, and taking effective action to address any needed improvements in the quality of care delivered to Seniors and People with Disabilities (SPD).
- Assuring availability and access to care clinical services and care management of SPD members.
- Ensuring the provision of case management, coordination and coordination of care services for SPD members.
- Continuously reviewing the quality of care provided to all SPD members to ensure that:
    - A level of care meets professionally recognized standards of practice is being delivered to all SPD enrollees;
    - Quality of care problems are identified and corrected for all provider entities;
    - Physicians who provide care are an integral part of the QI Program;
    - Appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the providers and/or others;
    - Blue Shield Promise does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training and experience.
- Utilizing a system or process to maintain and improve quality of care with respect to Medicaid-based services under Cal MediConnect.
- Delivering quality care that enables enrollees to stay healthy, get better, manage chronic illness and/or disabilities, and maintain/improve the quality of life of Cal MediConnect members.
- Applying Continuous Quality Improvement (CQI) principles to all aspects of Blue Shield Promise's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:
    - Quantitative and qualitative data collection and data-driven decision making;
    - Evidence-based practice guidelines;
    - Feedback from enrollees and providers;
    - Rapid cycle quality improvement;
    - Issues identified by Blue Shield Promise and regulatory entities;

- Addressing all aspects of health care, including specific reference to behavioral health, non-emergency medical transportation, and Long-term Services and Supports (LTSS), with respect to monitoring and improvement efforts, and integration with physical health care.

Scope

The scope of the Quality Improvement Program is to monitor and identify opportunities for improvement of care and services to both members and practitioners. This is accomplished by evaluating via identification, investigation, and implementation of corrective actions that continuously improve and measure the quality of clinical and administrative service. The Quality Improvement Program covers all medical products including, but not limited to, Medi-Cal. Behavioral Health is a covered benefit for the Medi-Cal line of business. A formal evaluation of the Quality Improvement Program is performed annually. Specific elements of the Quality Improvement Program may include but not limited to:

- Adverse outcomes/sentinel events
- Credentialing and re-credentialing
- Clinical measurement and improvement monitoring
- Compliance with regulatory requirements and reporting
- Delegation Oversight (Claims and Utilization Management)
- High risk and high-volume services
- Facility site reviews
- Initial Health Assessment
- IPA/Medical Group Oversight
- Medication Therapy and Management
- Medical record keeping practices
- Member safety
- Member satisfaction/grievances
- Peer Review
- Practitioner accessibility and availability
- Practitioner satisfaction/grievances
- Predictive Modeling
- Provider Incentives
- DHCS Performance Improvement Projects (PIPs)
- DHCS Plan-Do-Study- Act (PDSAs) aimed at improving HEDIS minimum performance levels

Confidentiality and Conflict of Interest

All information related to the quality improvement process is considered confidential. All Quality Improvement data and information, inclusive of but not limited to minutes, reports, letters, correspondence, and reviews, are housed in a designated, secured area in the Quality Improvement Department. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

All quality improvement activities including correspondence, documentation and files are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889 and the Health Information Portability and Accountability Act (HIPPA) for patient's confidentiality. All persons attending the Quality Management Committee (QMC) or its related committee meetings will sign a confidentiality statement, and all Blue Shield Promise Health Plan personnel are required to sign a confidentiality agreement upon employment. Only designated employees by the nature of their position will have access to member health information as outlines in the policies and procedures.

No persons shall be involved in the review process of Quality Improvement issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated.

9.1.1: Program Structure Governing Body

The governing body is the Board Quality Improvement Committee (BQIC). The Board Quality Improvement Committee is responsible for the establishment and implementation of the Plan's Quality Improvement Program. The Board Quality Improvement Committee (BQIC) appoints the Chief Medical Officer and Quality Management Committee as accountable entities for oversight of the Quality Improvement Program. The Chief Medical Officer reports all quality improvement activities monthly and the Quality Management Committee (QMC) reports all Quality Improvement activities to the Board Quality Improvement Committee every quarter. Board Quality Improvement Committee (BQIC) formally reviews and approves all quality improvement activities quarterly and directs these operations on an ongoing basis.

Committees

Quality Management Committee (QMC)

The Quality Management Committee is established by the authority of the Board Quality Improvement Committee (BQIC) as a standing quality oversight committee and is charged with the development, oversight, guidance and coordination of all Quality Management Department activities, including Quality Improvement and Utilization Management. The Quality Management Committee has a specific portion of the meeting designated for the Quality Improvement Program. The Quality Management Committee has been delegated the responsibility of providing an effective Quality Improvement Program. The Quality Management Committee monitors provisions of care, identifies problems, recommends corrective action, and guides the education of Practitioners to improve health care outcomes and quality of service. The Quality Management Committee, chaired by the Chief Medical Officer, is the primary Quality Oversight Committee. In addition, all subcommittees report up through the Quality Management Committee forming the new committee structure.

The following sub-committees report up to Quality Management Committee:

- Behavioral Health
- Credentialing/Peer Review Committee
- Medical Services
- Model of Care
- Pharmacy and Therapeutics
- Timely Access Committee

Scope *(includes but not limited to)*:

- Directing all Quality Improvement activity
- Recommending policy decisions
- Reviewing, analyzing and evaluating Quality Improvement activity
- Ensuring practitioner participation in the QI program through planning, design, implementation and review
- Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Behavioral Health, Credentialing, Medical Services, Model of Care, Peer Review, Pharmacy Therapeutics and Timely Access & Availability).
- Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program
- Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, DHCS, DMHC, and NCQA and L.A. Care
- Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols
- Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria

- Developing relevant subcommittees for designated activities and overseeing the standing subcommittee's roles, structures, functions and frequency of meetings. Ad-hoc subcommittees may be developed for short-term projects
- Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed
- Evaluating reports regarding any/all potentially litigious incidents and sentinel events
- Reviewing and evaluating reports submitted by the Plan's counsel
- Developing and coordinating Risk Management education for all Health Plan Practitioners and staff
- Responsibility for evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner Satisfaction surveys, access audits, HEDIS audits and IQIP studies
- Responsibility for evaluating and giving recommendations from monitoring and tracking reports
- Ensuring follow-up, as appropriate

Delegation

Blue Shield Promise Health Plan delegates responsibility for specific functional activities for the delivery of care and service to its members to IPA/PMGs. Blue Shield Promise Health Plan does not delegate Quality Improvement activities to contracted IPA's and Medical Groups. Blue Shield Promise maintains accountability and ultimate responsibility for the associated activities by overseeing performance in the following areas: Utilization Management, Credentialing, Culture and Linguistics and Health Education. Delegated functions include, but are not limited to preventive health services, health education activities, clinical practice guidelines, and access standards.

9.1.2: Standards of Practice

The standards of practice used as criteria, measures, indicators, protocols, practice guidelines, review standards or benchmarks in the Quality Improvement process are based on professionally recognized standards. These standards are used to evaluate quality of care of practitioners/providers and are incorporated into policies and procedures. Sources for standards include but not limited to:

- National and local medical professional associations
- Local professionally recognized practices
- Review of applicable medical literature
- Available medical knowledge
- State and federal requirements

Thresholds and targets derived from these standards and norms are:

- Measurable
- Achievable
- Consistent with national/community standards
- Consistent with requirements of regulatory agencies and legal guidelines

- Valuable to the assessment and improvement of quality for members

Standards are communicated to practitioners through the Plan in a systematic manner that may include but not limited to:

- Blue Shield Promise Health Plan Provider Manual
- Newsletters
- Bulletins
- Provider mailings

9.1.3: Quality Improvement Process

Blue Shield Promise Health Plan utilizes a Quality Improvement process to identify opportunities to improve both the quality of care and services for all Plan members. Blue Shield Promise Health Plan adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured. Compliance with standards is measured using a variety of techniques including, but not limited to:

- Quality Screens
- Chronic Care Improvement Plans
- HEDIS
- QIA Studies
- Monitors
- Indicators
- Medical Record Audits
- Facility Site Reviews
- Outcome Measures
- Focused Review Studies
- Member satisfaction surveys
- Member grievance and quality of care concerns resolution (see more below)
- Practitioner/Provider Satisfaction Surveys
- Access to Care Audits

Quality of Care Reviews

- Blue Shield has a comprehensive review system to address potential quality of care concerns. A potential quality issue arising from member grievances or internal departments is forwarded to the Blue Shield Quality Management Department where a quality review nurse investigates and compiles a care summary from clinical documentation including a provider written response, if available. The case may then be forwarded to a Blue Shield Medical Director for review and determination of any quality of care issues. A case review may also include an opinion about the care rendered from a like-peer specialist and/or review by the Blue Shield Peer Review Committee.

- During the review process, requests for additional information may be made to the IPA/Medical Group or directly to the involved provider. Upon review completion and dependent upon the severity of any quality findings identified, follow-up actions may be taken and can include a corrective action request or an educational letter outlining opportunities for improvement. Patient safety concerns or patterns of poor care can be considered during Blue Shield re-credentialing activities or reviewed in more detail by the Credentials Committee and may result in termination from the Blue Shield network.

- Contracted providers are obligated to participate in quality of care reviews and provide requested documents. Peer review activities are considered privileged communication under California Health and Safety Code section 1370 and California Evidence Code 1157. As such, neither the proceedings nor record of the review may be disclosed outside of the review process.

Quality Studies (HEDIS/QISMC/QIA/Focused Review Studies)

QI Department staff will perform quality studies, as indicated, based on findings from reviews of QCIs, utilization data, pharmacy data, complaints and grievances, satisfaction survey results, medical record audit results, facility site review results and other clinical indicators. In addition, Blue Shield Promise Health Plan will participate with collaborative plans and regulatory agencies in state- required HEDIS/QISMC/QIA studies. Studies conducted jointly with regulatory agencies will be in accordance with regulatory agency and state requirements. Quality studies conducted independent of regulatory bodies will be in accordance with Blue Shield Promise Health Plan policies and procedures.

Credentialing

Blue Shield Promise Health Plan conducts a credentialing process that follows all regulatory and oversight requirements.

9.1.4: Communication of Information

All Quality Improvement activities are presented and reviewed by the Quality Management Committee. Communication to the Quality Management Committee may include but not limited to:

- Access to Care (Appointment Availability, After-Hours, Ancillary)
- Delegation audit results
- Disability and Equality Program
- HEDIS and Quality Outreach summary
- Initial Health Assessment
- Facility Site Review and Patient Safety
- Member Call Timeliness and Abandonment Rate summary
- Member grievance statistics and trends
- Medical Record and Facility review audit reports and trends
- Study outcomes (Geo Access – Distance and Language Accessibility to providers)
- Policies and Procedures
- Provider and Member (CAHPS) Satisfaction survey results
- Quality Compliance
- Quality Improvement activities
- Quality Improvement Program, Work Plan, Annual Evaluation and Quarterly Reports
- Regulatory and legislative information

Results of Quality Improvement activities are communicated to Practitioners in the most appropriate manner including, but not limited to:

- Correspondence with the Practitioners showing individual results and a comparison to the group
- Correspondence with the IPA/PMGs showing results and comparisons to the network
- Newsletter articles
- Fax updates
- Provider Manual updates

The Quality Improvement Program description is made available to all practitioners and members. Members and practitioners are notified of the availability of the Quality Improvement Program through the Member Handbook, Provider Manual, and website, respectively.

Quality Improvement Program and Policies and Procedures

The Quality Improvement Program and its policies and procedures are reviewed annually and revised, as needed, to meet good medical practices; the needs of the Plan, its members and practitioners/providers; the changing demands of the healthcare industry, and regulatory requirements. The program and its policies and procedures are reviewed by the Chief Medical Officer then submitted to the Quality Management Committee and Board Quality Improvement Committee (BQIC) for review and approval.

Annual Work Plan

The Quality Improvement Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement. The work plan is developed annually outlining Quality Improvement activities for the year. The Work plan includes all activities not completed during the previous year, unless identified in the annual evaluation as issues that are no longer relevant or feasible to pursue. The work plan is reviewed by the Chief Medical Officer and submitted quarterly to the Quality Management Committee and Board Quality Improvement committee (BQIC) for evaluation, review and comment.

Annual Program Evaluation

Quality improvement activities, as defined by the Quality Improvement Work Plan, will be evaluated annually to measure the Plan's performance for the year and to assist in revising the Quality Improvement program and preparing the following year's work plan. The evaluation is reviewed by the Chief Medical Officer and submitted to the Quality Management Committee and Board Quality Improvement Committee for review and approval.

9.2: Policies and Procedures

9.2.1: Confidentiality of Quality Improvement Information

Policy

All Quality Improvement activities designed to monitor or improve medical care shall remain confidential. All information related to the Quality Improvement process is considered confidential. All Quality Improvement data and information including, but not limited to, minutes, reports, letters, correspondence, and reviews are housed in a secured area in the Quality Improvement Department. All aspects of a quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the Quality Management Committee and any of its subcommittees.

Confidentiality shall be maintained in accordance with all applicable laws and regulations and standards of practice.

Procedure

1. All member-identified information is kept confidential by all employees, consultants and caregivers, except to the extent needed to accomplish appropriate coordination and continuity of care among medical, nursing, ancillary and other team members who may need to exchange information for provision of care.
2. Member protected health information (PHI) can only be reviewed by Quality Improvement personnel that are involved in the actual investigation of the issues. This includes the Chief Medical Officer, Quality Improvement Directors, Quality Improvement Managers, Quality Improvement Nurse Specialist and the Quality Improvement administrative assistant. The Chief Medical Officer is ultimately responsible for assuring the protection of Protected Health Information.
3. All member information is considered Protected Health Information and will be de-identified prior to being presented to the committee for review. Member information includes but is not limited to names, addresses, dates, telephone numbers, fax numbers, e-mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, serial numbers, URLs, internet address, biometric identifiers and photographs.
4. All case files will be protected and kept in a secured, locked area at all times. Office printers and copiers used for this information will be kept in a secure location, where only the authorized personnel (see above) will have access.
5. Only the minimum necessary information will be requested for the review and investigation of these issues.
6. Member-identified information may also be shared in the following circumstances:
    a. As consented to as part of an insurance plan and then held in confidence as part of Plan policy.
    b. As required by state and federal agencies and their designees as part of medical record availability, eligibility information, requests for authorization or referral to their agencies or their designees.
    c. De-identified member issues are discussed within the confidentiality protection of the Quality Management Committee and other peer review bodies. Committee members and staff shall sign and adhere to a Confidentiality Statement as it relates to the committee's functions.
7. All members of the Quality Management Committee, Medical Services, Pharmacy & Therapeutics, Credentialing and Peer Review Committees and any subcommittees of those committees will sign a confidentiality statement, which shall remain in effect for a one-year period and will be maintained in the appropriate department.
8. Any employee, consultant or representative in any way involved in the Quality Improvement process will sign a confidentiality statement upon employment or contract inception.

9.3: Quality of Care Focused Studies

Policy

The Blue Shield Promise Health Plan Quality Improvement Department develops quality improvement studies based on data collected through various methods including, but not limited to, encounter data, claims data, complaints and grievances, potential quality of care issues (PQI), access and availability surveys, and satisfaction surveys. Blue Shield Promise Health Plan participates with regulatory agencies in the state-mandated Quality Improvement System for Managed Care (QISMC), Health Plan Employer Data and Information Set (HEDIS), and Quality Improvement Activities or Projects (QIAs or QIPs). Studies conducted in collaboration with other health plans and state-wide collaborative Quality Improvement Projects will be conducted in accordance with regulatory agency requirements. Focused review studies conducted independent of a regulatory agency will be in accordance with the procedures as described herein.

Procedure

1. Focused review studies will include the following design elements:
    - Objective and reason for topic selection
    - Sampling framework and sampling methodology
    - Data collection criteria and analysis methodology
    - Report of data and/or findings
    - Quantitative/Qualitative analysis Barrier analysis
    - Action plans, as appropriate
    - Reassessment, as appropriate

2. The study will be designed to produce accurate, reliable, and meaningful data in accordance with standards of statistical analysis. The study questions will be framed using information from scientific literature, professional organizations, practitioner/provider representatives, regulatory requirements, and outcome-related data. The practice guidelines/ quality indicators used in the study will be specified, whenever possible. The variables to be collected and analyzed will be defined and derived from the practice guideline/quality indicators.

    Data may be collected through a variety of methods including, but not limited to member surveys, practitioner/provider surveys, medical record audits, on-site practitioner/ provider facility inspections, analysis of encounter/claims data, analysis of prior authorization data, and analysis of Member complaints and grievances.

    a. Data may be collected through sampling or may include the entire population that meets the study criteria. The following criteria should be considered in making this decision:
        - The size of the member population eligible for study.
        - The method of data collection (e.g., administrative data, medical record review or hybrid of both).

- The nature of data to be collected.
- The degree of confidence required for the data.

b. The following questions will be used to determine the method for validating the results:
   - How will the raw data collected be verified?
   - What statistical analytical tests will be performed on the data?
   - What adjustments for age, severity of illness, or other variables, which may affect the findings, will be made?
   - What is an acceptable level of performance?

3. The Quality Improvement Department, in conjunction with the Chief Medical Officer will analyze and interpret study results and develop a corrective action plan to address the findings. Results will be compared to recognized, relevant benchmarks, when available. Action plans will include:
   a. Expected outcomes that must be expressed in measurable terms
   b. Specific interventions/actions to be taken to positively impact the problem.
   c. Improvement actions/interventions may include but are not limited to the following:
      - Assign members to case manager for specialized attention
      - Re-engineer organizational processes and structures
      - Provide members with educational materials or programs
      - Develop member incentive programs
      - Introduce new technology to streamline operations
      - Develop employee-training programs to improve understanding of health practices of various cultural groups
      - Disseminate practitioner/provider performance data to allow peer measurement
      - Provide educational materials that may be relevant to understanding and treating the population to practitioners/providers
      - Develop clinical practice guidelines through collaboration with plan partners and other collaborative plans
      - Address any practitioner/provider-specific concerns through the peer review process
   d. Implementation schedule
   e. Monitoring plan

4. The results, interpretation and action plan will be presented to the Quality Management Committee for review and approval and then forwarded to the Board Quality Improvement Committee.

5. Reports will be made to the Quality Management Committee as required by the action plan.

6. Results will be made available to members and practitioners through newsletters, bulletins, faxes, special mailings, etc., as appropriate.

7. Sources for standards, norms and guidelines pertaining to the measurement of quality of care include, but are not limited to, the following:

    - National Committee of Quality Assurance standards for quality and utilization management.
    - Other independent credentialing, certification and accreditation organizations, including Department of Health Care Services (DHCS), Centers for Medicaid & Medicare Services (CMS), JCAHO, CMRI, The Quality Commission, AAAHC and URAC.
    - HEDIS Medicare performance standards. Medicare performance standards.
    - Federal Agency guidelines including the Centers for Medicaid & Medicare Services (CMS), Office of Technology Assessment (OTA), Agency for Healthcare Policy and Research (AHCPR), National Institute of Health (NIH), Department of Health and Human Services (DHHS), Center for Disease Control (CDC), and the United States Public Health Services (USPHS).
    - United States Preventive Services Task Force (USPSTF) guidelines.
    - National consensus organization guidelines for clinical practice.
    - Child Health and Disability Prevention (CHDP) program guidelines.
    - Professional specialty service guidelines, including American Academy of Family Practice, American College of Physicians, American Academy of Pediatrics, American College of Obstetrics and Gynecology, and the American Medical Association.
    - English language peer reviewed medical literature.
    - Milliman Care Guidelines.
    - Pharmacology guidelines extracted from the practice standards of the American Society of Hospital Pharmacists (ASHP) and the PDR.
    - Expert opinion.
    - HMO standards for access to ambulatory care.
    - InterQual Severity of Illness/Intensity of Service (ISSI).
    - Commission for Professional Activity Studies (PAS) length of stay norms.

9.4: Practitioner/Provider and Member Satisfaction Surveys

Practitioner/Provider Satisfaction Survey

Blue Shield Promise will conduct a practitioner satisfaction survey with all contracted Primary Care Providers and specialists at least annually using an NCQA-certified vendor. Results will be summarized and reported to the appropriate departments and committees for follow-up and action.

Member Satisfaction Survey

Blue Shield Promise will conduct a Member Satisfaction Survey at least annually using a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor. Results will be summarized and reported to the appropriate departments and committees.

9.5: Clinical Practice Guidelines

Policy

Blue Shield adopts nationally recognized clinical practice guidelines which are reviewed and approved annually through our committees and is overseen by our Utilization Management department.

9.6: Initial Health Assessment ("IHA")

Purpose

To establish the patient/doctor relationship and obtain necessary health care and preventive services, which can lead to positive health outcomes and improvement in their overall health status. All newly enrolled members must receive an Initial Health Assessment (IHA) within 120 days of enrollment. (Policy Letter 08-003) http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx

Policy

The IHA consists of a comprehensive health history (medical, social, family, etc.), physical exam, including a review of systems, and the completion of the Staying Healthy Assessment. This visit should include, but is not limited to, immunizations (ACIP Guidelines), counseling including Tobacco Cessation, medical testing and treatment, review of Preventative Services (USPSTF).

During their Initial Health Assessment, members need to complete an Individual Health Education Behavioral Assessment (IHEBA) also known as a SHA (Staying Healthy Assessment form) in the appropriate age category for them. The IHEBA can help you identify risky health behaviors in order to promote positive lifestyle changes. You are able to download forms on the Blue Shield Promise Health Education for Medi-Cal Providers Website under Staying Healthy Assessment (SHA).

In our efforts to coordinate with our providers, Blue Shield Promise conducts outreach to all new members to ensure timely access to an IHA. Members receive phone calls and letters notifying them of the available service and encouraging them to call their PCP to make an IHA appointment within 120 days of enrollment. Blue Shield Promise also sends a letter to the PCPs notifying them of their newly assigned member and reminding them of the requirements to conduct a timely IHA. We will follow-up with the PCP to verify if member outreach was conducted or effective follow-up was done to schedule the IHA. Please be advised your office may be randomly selected to participate in the IHA medical record review utilizing the IHA Audit Tool. Blue Shield Promise will coordinate with our members and providers as follows:

1. A minimum of three documented attempts must be made to schedule the timely IHA, with at least one phone call and one letter.
2. Notify Members of the importance and availability of IHAs through the Member Telephone outreach, Member letter, EOC, and newsletters.
3. Notify practitioners/providers of the requirement for IHAs through the Provider Manual, newsletters, provider letters, fax blast and telephone.
4. Monitor compliance by Monthly IHA provider file review.
5. Follow-up with the Member and practitioner/provider when an IHA has not been performed within 120 days of enrollment with Blue Shield Promise.

As referenced in Title XVII and the United States Preventive Services Task Force (USPSTF), and the American Academy of Pediatrics (AAP) members is entitled to and should receive timely access to an IHA or, alternatively, should have documentation in the member's medical record that a comparable assessment has been performed within the last 12 months.

Although, there is no specific form, complete documentation of this visit is required to be kept in the member's medical record (Age-appropriate physical evaluations templates are available on Blue Shield Promise Health Plan Health Education for Medi-Cal Providers Website under IHA. Provision of the assessment or that of a comparable comprehensive assessment needs to be documented in the member's medical record).

Health Assessment Services Include:

1. Health assessments for Members under 21 years of age must include, at minimum (Pediatric patients should receive CHDP Health Assessments per the CHDP periodicity schedule.)

2. Blue Shield Promise requires Practitioners to complete an age-appropriate Staying Healthy Assessment form/Individual Health Education Behavioral Assessment with the initial visit.
   - Complete Health and developmental history
   - Psychosocial behavioral assessment
   - Blood Pressure before 3 years old for at risk patients, BMI, Height & Weight and Head Circumference from <1-8 months.
   - Unclothed physical examination, including assessment of physical growth
   - Inspection of ears, nose, mouth, throat, teeth and gums
   - Assessment of nutritional and dental status
   - Hearing and vision screening, as appropriate
   - Immunizations as recommended by Advisory Committee on Immunization Practices (ACIP) and Centers of Disease Control (CDC) and tuberculosis (TB) testing appropriate to age and health history necessary to make status current
   - Lab tests appropriate to age and/or sex, including testing for anemia (Hb/Hct starting at age 9-12 months, diabetes, blood lead screenings, sickle cell trait, ova & parasites, STD, VDRL, annual gonorrhea, chlamydia and pap smear if sexually active, and urinary tract infections.
   - Tobacco screening, prevention and cessation
   - Health education and anticipator guidance appropriate to age and health status

3. Health Assessments for Asymptomatic Members 21 years of age and older must include, at minimum:
   - Blue Shield Promise requires Practitioners to have an age appropriate Staying Healthy Assessment form/Individual Health Education Behavioral Assessment with the initial visit.
   - Complete history and physical examination, which includes inspection of ears, nose, mouth, throat, teeth and gums
   - Blood pressure
   - Height and Weight
   - Total serum cholesterol measurement for men ages 35 and over and women ages 45 and over.
   - Clinical breast exam for women over 40 years of age
   - Mammogram, within two (2) years for women over 40 years of age and within one (1) year for women 50 and above. 40-49 with the potential for high risk biennial.

- Cervical cancer screen (pap smear) for women beginning at the age 21-65 of first sexual intercourse and once every 1-3 years depending on the presence or absence of risk factors and the results of previous pap smear. Women age 30-65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
- Chlamydia screen for all sexually active females age 24 and older who are determined to be high risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females 21-26 years of age.
- PPD- Screening for TB risk factors a Mantoux skin on all persons determined to be at high risk.
- Initial and annual assessment of Tobacco use for each adolescent and adult member (APL 16-014)
- Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal beneficiaries the (USPSTF) recommends clinicians ask all adult beneficiaries including pregnant beneficiaries, about tobacco use advise them to stop using tobacco and provide them with behavioral interventions. The USPSTF recommends that primary care clinicians provide interventions, including education, or counseling, to prevent initiation of tobacco use in school-aged children and adolescents. Additionally, since secondhand smoke can be harmful to children, counseling parents who smoke, in a pediatric setting, is also recommended.
- Health education and anticipatory guidance appropriate to age and health statistics
- Fecal occult blood testing every year after age 50
- Sigmoidoscopy at least once at age 50
- Rectal exam at least once every 5 years after age 50
- Prostate specific antigen (PSA) testing for men 45 with high risk and annually after ages 50-70 for men with average risk.
- Exam of testes for men
- Rubella antibody screening for women of childbearing age at least once prior to first pregnancy
- Immunization for tetanus-diphtheria (Td) at least every ten (10) years
- Immunizations as recommended by the current ACIP and CDC schedules.
- Blue Shield Promise will require Practitioners to document each member's need for ACIP recommended immunizations as part of all regular health visits, including, but not limited to the following types of encounters:
    - Illness, care management, or follow-up appointments
    - Initial Health Assessments (IHA)
    - Pharmacy services
    - Prenatal and postpartum care
    - Pre-travel visits
    - Sports, school, or work physicals
    - Visits to a Local Health Department (LHD)
    - Well patient checkups

Procedure

1. In collaboration with our providers, Blue Shield Promise Health Plan conducts outreach to all new members to ensure timely access to the IHA. Members will receive phone calls and letters notifying them of the available service, offering assistance to schedule an IHA or encouraging them to call their PCP to make an IHA appointment within 120 days of enrollment.

2. Blue Shield Promise will send a letter to the PCP notifying them of their newly assigned member and reminding them of the requirements to conduct a timely IHA. Follow-up with the PCP will be done to verify if member outreach was conducted or effective follow-up was done to schedule the IHA.

3. The Member Handbook, distributed at the time of enrollment, contains both basic information about PCP services and specific information describing the importance of the IHA. It encourages Members to access this service. Members are specifically directed, in their Blue Shield Promise new Member packet, to contact their PCP's office to schedule an IHA.

4. Blue Shield Promise Provider Relations representatives educate contracted practitioners/ providers on the 120-day health assessment requirements. Practitioner/ Provider bulletins and newsletters are used to reinforce awareness of the compliance and tracking process.

5. Blue Shield Promise contracts with 4Patient Care, an automated member outreach system, to provide an automated outreach call to the member in order to assist the member to schedule an IHA appointment. Upon receiving updated eligibility lists, PCP offices, should contact new Members, by mail and/or telephone to assess the current need for an IHA and to schedule an appointment, if necessary. A minimum of three documented attempts, including at least one telephone call and one mail notification to assess the current need for an IHA and to schedule an appointment, if necessary. If a comprehensive health assessment has recently been performed elsewhere, the PCP shall obtain the appropriate records and document this in the medical record. Exceptions to 120-day IHA timeframe; all elements of the IHA have been completed within 12 months prior to the member's effective date of enrollment.

6. When a significant health problem, requiring further evaluation or referral, is identified, the PCP will be responsible for scheduling an appointment date for follow-up within 60 days.

7. If a Member refuses an IHA, the refusal must be documented in the medical record or on the eligibility list until the member comes to the office.

9.7: Facility Site Review

Overview

The facility site review process ("FSR") is a comprehensive evaluation of Blue Shield Promise Health Plan Primary Care Physician offices and includes a review of the physical site, administration, policies and procedures, medical record keeping practices, as well as other critical areas, to demonstrate contractual requirements are met and maintained. Blue Shield Promise Health Plan maintains policies and procedures that ensure the FSR Program follows the Department of Health Care Services ("DHCS") Policy Letter 14-004, or current version, and Title 22 Regulatory requirements, which are mandatory under Blue Shield Promise's contract with DHCS and LA Care Health Plan (for Los Angeles County). Each Primary Care Physician's site will be evaluated at the time of initial credentialing and at least every three (3) years by Blue Shield Promise Health Plan, a contracted reviewer or a County Collaborative Health Plan, according to the requirements. Blue Shield Promise Health Plan does participate in the Site Review Collaborative in the County where your site(s) is/are located and will accept reviews completed by Certified Site Reviewers from other contracted Health Plans in the same county, as well as bordering counties. A complete facility review audit tool is included at the end of this section for your review. Additional resources are available. For further information please go to the Blue Shield Promise Health Plan website www.blueshieldca.com/promise/provider/index.asp.

9.7.1: FSR Evaluation Tools

Policy

The Facility Review is a comprehensive evaluation of the Access/Safety, Personnel, Office Management, Clinical Services, Preventive Services, and Infection Control related to your physical location. The reviews are conducted by a Certified Site Review Nurse using the attached tools that have been approved by Blue Shield Promise Medical Director's. Blue Shield Promise Health Plan will utilize the current DHCS Medical Record Review tool to evaluate readiness and compliance with DHCS requirements – DHCS Policy Letter 14-004, or current version, Attachment A (see Facility Site Review Policy and Procedures https://www.blueshieldca.com/promise/media/pdf/providers/Facility_Site_Review_Policy_and_Procedures.pdf)

Procedure

1. An FSR will be conducted by Blue Shield Promise Health Plan upon receipt of a request from Provider Network Administrators or Credentialing prior to any Primary Care Physician's site being added to the practitioner/provider network.

2. The FSR Coordinator will process an FSR for all sites within 60 days of receipt of a request for an FSR or at least 90 days prior to their three-year or annual FSR anniversary date.

3. The FSR will be conducted using the most current review Survey tool as directed by the DHCS and approved by the Blue Shield Promise Health Plan Medical Directors.

4. Practitioners/Providers for initial credentialing and recredentialing will be contacted a minimum of three (3) times to schedule a mutually agreed upon date and time to conduct the review. If Blue Shield Promise Health Plan is unsuccessful in contacting a site, an auto-scheduled date will be generated in order to complete the review by the required timelines.

5. The Facility Site Review unit will send a confirmation letter along with a link that contains sample copies of the tools to be used as well as a set of policies and procedures and forms that your office can use to update the office policies and procedures to meet criteria from the Center for Medicare & Medicaid Services and the California Department of Health Care Services.

6. The reviewer will arrive at the scheduled time and conduct the review. The reviewer will be courteous, thorough and helpful. If a reviewer cannot answer a question, he/she will take the question back to the supervisor or manager of the facility site review staff and will contact the office with the answer.

7. After completing the review, the reviewer will score the facility according to the approved scoring guidelines. Compliance will fall into the following categories:
   - Exempted Pass: 90% and above without deficiencies in Critical Elements, Pharmaceutical or Infection Control sections
   - Conditional Pass 80-89%, or 90% and above with deficiencies in Critical Elements, Pharmaceutical or Infection Control sections
   - Not Pass 79% and below
   - A Corrective Action Plan (CAP) is required for all sites that have a deficiency in a critical element, Pharmaceutical, or Infection Control sections, regardless of score

8. Any CAP considered critical, if required, is due within 10 business days of the date of the review. A non-critical CAP for the rest of the deficiencies will be due 30 days from the date of the review.

9. Blue Shield Promise Health Plan staff is available to assist practitioners/providers with the review preparation and CAP completion.

10. New Practitioners/Providers sites may request for an educational visit. For those providers who score below 80% will not be admitted to the network until they have corrected all deficiencies and have submitted evidence of corrections to deficiencies found. Such providers must submit evidence in order to be considered for another review and receive a passing score.

11. Practitioners/Providers that score 80 to 89% and do not submit a CAP or CAPS within required time frames will be referred to the Medical Director and Credentialing Committee for further action, which may include but is not limited to: immediate closure of panels to new membership, annual audit and/or termination from the network.

12. Blue Shield Promise Health Plan and the practitioners/provider's delegated PPGs will contact practitioners/providers who do not submit their CAP within the required timeframes to offer assistance.

13. Blue Shield Promise Health Plan follows the DHCS FSR guidelines as written in Policy Letter 14-004, or current version. Additional information, including review requirements and regulatory timelines, are included in this document for review.

9.7.2: Facility Review Tool Purpose

To set forth minimum requirements for a contracted PCP office site.

Policy

1. Convenient, adequate parking is available, some of which must be accessible to disabled persons or reasonable alternates are in place.

2. The facility is neat, clean, and well organized. Adequate storage space is available so that patient care areas are not unnecessarily cluttered. Electrical wiring is covered and concealed according to building codes. Incandescent bulbs and fluorescent tubes are covered. Floors, walls and ceilings are in good repair. Lighting is adequate.

3. Waiting areas have sufficient floor space and seating capacity to accommodate the typical patient load.

4. The number of examination and treatment rooms is adequate to accommodate patient needs.

5. There is at least one exam room that can be designated for patients with contagious or infectious diseases.

6. The number of adult, pediatric, and obstetrical examination tables is adequate to meet patient needs.

7. The office hours of operation are available upon request or posted within or outside the office door. Emergency telephone number(s) are updated annually and posted in easily accessible locations to office staff.

8. Policies and procedures for housekeeping must be maintained including specific responsibilities of personnel and a procedure for regularly monitoring completion of specified tasks.

9.7.3: Physical Accessibility

Purpose

To assure easy access to medical offices for our disabled members.

Policy

The physical accessibility needs of our disabled members will be met to provide equal and appropriate access to health care treatment and services and our network of providers.

Blue Shield Promise Health Plan will utilize the current DHCS Physical Accessibility Review Survey tools to assess provider sites:

- Attachment C – Primary Care and Specialty Care Providers
- Attachment D – Ancillary Care Providers
- Attachment E – Community Based Adult Services (CBAS) Providers

Procedures

1. Designated parking with adequate signage is provided within a reasonable distance from the facility's main entrance.
2. Wheelchair access to the main entrance is easy via a ramp or absence of stairs or steps.
3. Restroom doors of at least one restroom are wide enough to accommodate wheelchair users.
4. Adequately secured handrails near toilets are provided in at least one restroom within the facility.
5. All features for the disabled are marked by adequate signage.
6. Facility features designed specifically for disabled access (e.g., specifically designated parking spaces, sign postings directing Members to special restrooms, handrail, etc.) are regularly inspected, and repaired or replaced if necessary.
7. Grievances, complaints and member disenrollments mentioning inadequate disabled access are carefully analyzed to determine areas where improvements can be made. Identified needed improvements are made promptly.
8. In-floor weight scales and height adjustable exam tables are available for use.

9.7.4: Medical Equipment

Purpose

To ensure that each contracted medical office maintains an appropriate set of medical equipment in a good state of repair.

Policy

Practitioner/Provider offices will maintain all medical equipment according to manufacturer recommendations and/or community standards of practice.

Documentation of testing and inspections, including logs and certifications will be maintained in accordance with established policies.

Procedures

1. The following equipment is available within the facility (as it relates to services and population practice sees):
   a. Scales
      - Weight scale
      - Infant weigh scale (if seeing pediatric patients)
   b. Blood pressure cuffs
      - Standard Adult size
      - Extra Large or Thigh
      - Pediatric
   c. Stethoscopes
   d. Vision eye charts with distance marker based on the type of chart and with adequate lighting:
      - Kindergarten or Symbol
      - Snellen
      - Occluder (disposable or with cleaning solution and appropriate cleaning procedure in place)
   e. Autoclave
      - Proper sterilization procedures are in place, including monthly spore testing.
      - Proper cleaning and maintenance procedures are in place, including periodic inspection and calibration.
      - Autoclave documentation is maintained onsite, including autoclave cycle details, spore testing and maintenance records.
   f. Otoscopes
   g. Ear speculums are available for use.
   h. Opthalmoscopes
   i. Thermometers
      - Digital thermometers are recommended
   j. Refrigerator with an independent freezer section or individual units
      - Temperature is maintained between 36- and 46-degrees F (or 2 and 8)
      - Daily temperatures are read and documented. Escalation procedures are in place in the event of an out-of-range reading.

- Is not used for food storage
- May be used to store laboratory samples if these samples are kept in separate solid covered section of refrigerator, i.e. the bottom (vegetable) drawer section refrigerator/freezer

k. Audiometer if seeing patients from 3 through 21 years of age
l. Tape measure for head circumference measurement (1/8 inch or 1 mm) if seeing infants
m. Pediatric length measuring device with right angle block
n. Wall measure device with right angle block
o. Exam gloves, gowns and masks. Exam gowns should be available in adult and pediatric sizes as it is appropriate for the population served
p. Scales are inspected and balanced annually
q. All medical equipment is calibrated annually:
    - Equipment determined to be unsafe, nonfunctional and beyond repair is promptly replaced.
    - Current inspection/calibration stickers are affixed to equipment and are clearly visible. These stickers include the name of the inspector and the date of last inspection.
    - Staff is properly trained in the use of the audiometer, autoclave and other equipment.
    - Evidence of the age of the equipment inspection/calibration is maintained
    - Evidence of staff training on use of equipment is maintained in employee personnel records

9.7.5: Fire and Earthquake Safety

Purpose

To assure PCP offices meet minimum fire and earthquake safety requirements:

Policy

1. The facility is maintained in compliance with all applicable local, state and federal fire and general safety requirements.
2. The facility has a current fire inspection certificate issued within the preceding 12 months indicating that acceptable local standards are met.
3. Exit signs are clearly visible and appropriately located.
4. Emergency evacuation maps are easily readable and appropriately located in hallways and in all exam rooms.
5. The office maintains a written emergency evacuation plan. The plan includes specifications for staff Members with responsibility for evacuating patients and staff, and procedure for notifying fire and/or police departments.
6. Fire extinguisher are regularly inspected (e.g., once every 12 months) and readily accessible to staff.
7. Covered containers are used for regular (non-infectious) waste.

Procedure

1. Current inspection tags are securely attached to extinguishers if a fire inspection has been done within the last 12 months.

2. Regular reviews of fire safety features (e.g., exit signs, evacuation maps, etc.) are scheduled.

3. The written emergency evacuation plan is discussed in new employee orientations and is readily accessible to all staff. The plan is regularly reviewed and updated to reflect changes in the physical plan, changes in safety codes, etc.

4. Evidence of non-medical emergency protocol training is documented and maintained in every employee's file.

5. Response to a Fire
   - Sound the alarm either with the pull alarm station or telephone.
   - If using the telephone, give the location and extent of the fire.
   - Warn others near you.
   - Check doors before opening for heat. If hot, do not open.
   - Open doors slowly and be prepared to close doors quickly.
   - Evacuate all patients and other employees who are in immediate danger.
   - If you have time and there is no immediate danger, close all window and doors in the area.
   - Do not use elevators.
   - Above all, remain calm.

6. Earthquake Safety
   - Assign responsible person(s) to coordinate response to an earthquake.
   - Move away from windows and glass.
   - Take cover under a sturdy desk, table.
   - After the quake, assess damage and check other around you for injury.
   - Provide first aid, if qualified.

Follow instructions to move patients and/or evacuate building.

9.7.6: Emergency Equipment and Medications Policy

Each practitioner/provider office shall ensure that it has sufficient supplies and equipment on hand for handling medical emergencies. All clinical staff shall be trained in emergency procedures and the appropriate use of emergency equipment and supplies. Records of this training shall be maintained at the practitioner/provider site.

Procedures

1. Each practitioner/provider office, according to the population age served, shall maintain an emergency kit which at minimum will contain the following:
    - Benadryl (injectable and/or oral)
    - Epinephrine (injectable)
    - Dosage instructions for all emergency medication is included in the emergency kit
    - Ambu Bags- Adult, small adult, pediatric and infant
    - Oxygen Masks/Nasal Cannula, Adult, Pediatric, and infant
    - All size airways- Adult, Child and Infant
    - Oxygen Tank with a fail gauge and a flow meter maintained at least 3/4th full or greater and with a replacement tank readily available
2. A written inventory of emergency equipment/supplies must be maintained. It shall be checked and signed off by a designated staff Member at least monthly.
3. The emergency kits must be readily available, not requiring an assistive device to retrieve the kit. As well as remain inaccessible to unauthorized personnel.
4. Telephone numbers for emergency services and the local poison control center shall be posted at the front desk area and preferably in the area where emergency supplies are stored.

9.7.7: Infection Control

Purpose

To ensure that bio-hazardous waste is handled and disposed of in accordance with all applicable laws and regulations.

Policy

All practitioner/provider offices are required to have in place policies and procedures to ensure that bio-hazardous waste is handled and disposed of in accordance with all applicable laws and regulations. Staff training related to handling of bio-hazardous waste must be kept on site both current and historical.

Procedure

Cleaning of exam rooms, equipment and surfaces

1. Must be done daily using a solution that is EPA Certified to kill HIV, Hepatitis B and C, and TB.
2. Written Schedules are available showing frequencies for routine cleaning, the disinfectant used and the responsible personnel.

Handling and Disposal of Bio-hazardous Waste

1. Bio-hazardous waste must be handled and disposed of in accordance with all applicable laws and regulations of the Department of Environmental Health Services (DEHS) of the County of Los Angeles and any other local health laws and regulations.
2. Bio-hazardous waste must be contained in a manner and location which afford protection from animals, rain and wind and does not provide a breeding place or food source for insects or rodents.
3. Bio-hazardous waste must be separated from other waste at the point of origin in the producing facility, i.e. separate containers for regular waste and bio- hazardous waste.
4. Bio-hazardous waste must be transported to an off-site treatment or disposal facility by a hauler registered as a hazardous waste hauler by the Department of Environmental Health Services (DEHS) of the County of Los Angeles or the provider has a limited hauling quantity exemption that is current and kept on-site. Limited hauler services are permitted as long as within regulations.
5. "Medical waste" Includes all of the following:
    a. Viral hazardous waste or sharps waste.
    b. Waste which is generated or produced as a result of the diagnosis, treatment or immunization of patients.
6. "Bio-hazardous waste" Means any of the following:
    a. Viral hazardous waste or sharps waste.
    b. Waste which is generated or produced as a result of the diagnosis, treatment or immunization of patients.
    c. Laboratory waste, including, but not limited to, all of the following:
    d. Human specimen cultures from medical and pathological laboratories.
    e. Wastes from the production of bacteria, viruses or the use spores, discarded live and attenuated vaccines and culture dishes. devices used to transfer inoculate and mix cultures.
    f. Waste containing any microbiologic specimens sent to a laboratory for analysis.

g. Human surgery specimens or tissues removed at surgery, which are suspected by the attending physician and surgeon of being contaminated with infectious agents known to be contagious to humans.

h. Waste, which at the point of transport from site, at the point of disposal, or thereafter, contains recognizable body fluid products.

i. Containers or equipment containing body fluid products, which are known to be or could possibly be infected with diseases that are communicable to humans.

j. Waste containing discarded materials contaminated with excretion, exudates, or secretions from humans that are required by infection control staff, the attending physician or surgeon or the local health officer to be isolated in order to protect others from communicable diseases.

7. "Sharps waste" Means any device having acute rigid corners, edges, or protrusions capable of cutting or piercing including, but not limited to, the following:

a. Hypodermic needles, syringes, blades, and needles with attached tubing.

b. Broken glass items, such as Pasteur pipettes and blood vials.

HEALTH AND SAFETY CODE- HSC DIVISION 104. ENVIRONMENTAL HEALTH [106500.-119405.] (Division 104 added by Stats. 1995, Ch. 415, Sec. 6.)

PART 14. MEDICAL WASTE [117600.-118360.] (Part 14 added by Stats. 1995, Ch. 415, Sec. 6.) **CHAPTER 9.**

Containment and Storage [118275.-118320] (Chapter 9 added by Stats. 1995, Ch. 415, Sec. 6.)

118280

(A) If the person generates 20 or more pounds of bio-hazardous waste per month, the person shall not contain or store biohazardous or sharps waste above 0° Centigrade (32° Fahrenheit) at any onsite location for more than seven days without obtaining prior written approval of the enforcement agency.

(B) If a person generates less than 20 pounds of bio-hazardous waste per month, the person shall not contain or store bio-hazardous waste above 0° Centigrade (32° Fahrenheit) at any onsite location for more than 30 days.

1. To contain or store medical waste, Blue Shield Promise Health Plan site will ensure the following:
    a. All examination and treatment rooms and laboratory areas have both regular waste cans and biohazardous waste cans.
    b. All bio-hazardous waste cans must be the step-on variety and contain a red plastic bag liner. The can must be labeled using the International Bio-hazardous Label.
    c. A separate non-breakable, secured (locked) leak-proof container must be used for disposal of sharps (i.e., used syringes or blood drawing equipment) and are not used for the disposal of dressing and similar items.
2. To contain bio-hazardous waste in a bio-hazard bag:
    a. The bags will be tied to prevent leakage or expulsion of contents during all future storage, handling, or transport.
    b. Bio-hazardous waste will be bagged and placed for storage, handling, or transport in a rigid container. The container will be leak resistant, have tight fitting covers, and be kept clean and in good repair.
    c. The container may be of any color and will be labeled with the International bio- hazardous label on the lid and on the sides so as to be visible from any direction.
    d. Place all sharps waste in a sharps container that is leak proof, rigid and puncture resistant or liquid or semi-liquid waste will be discarded using absorbent material and placed in a bio-hazardous bag.
    e. Full sharps containers will be stored in the bio-hazardous storage unit for disposal by the certified waste hauler.

3. Reusable bio-hazardous containers are stored in a secured, locked area that is inaccessible to unauthorized personnel.
4. Broken, cracked or otherwise compromised bio-hazardous containers must be replaced immediately by the bio-hazardous waste hauler.
5. Blue Shield Promise Health Plan facilities will not use a trash chute to transfer medical waste.
6. Medical waste in bags or other disposable containers will not be subject to compaction by any compacting device and will not be placed for storage or transport in a portable or mobile trash compactor.

Autoclave Procedures

1. An autoclave must be maintained in good repair for steam sterilization and certified annually or as directed by the manufacturer's instructions.
2. An autoclave that is not working must be marked and information kept as to when it will be picked up or services.
3. An autoclave that is not being used should be removed from the office laboratory, exam or multipurpose room immediately.
4. Follow the manufacturer instructions for wrapping items and for loading and operating the autoclave.
5. Sterilized equipment is clearly marked with the sterilization date, load number and initials of the individual running the load. Packages are considered sterile until the package is damaged, discolored or used.
6. An autoclave log must be maintained and record the following information:
   - Date and time
   - Load number
   - Load contents
   - Temperature and Steam Pressure
   - Duration of run
   - Initial of the operator
7. Expired sterilized equipment must be made inaccessible to practitioners/providers until it has been re-sterilized.
8. A regular schedule of inspections and calibrations is maintained along with monthly spore testing. Spore testing results are maintained for at least three (3) years.
9. There is a written procedure to follow if a spore test is positive.
10. Staff responsible for autoclaving can verbalize their process

Cold Sterilization

1. Cold sterilization is acceptable for reusable surgical instruments and reusable diagnostic equipment. The following minimal steps are required:
   a. Clean items after each use by washing them in a solution of Hot water and an enzymatic detergent.
   b. Completely submerge the cleaned items in sterilization solution. The item is considered sterile after it has been submerged for the period indicated by the solution manufacturer.
   c. Rinse items in sterile water immediately prior to use, wearing sterile gloves, drying with a sterile towel and placing on a covered sterile tray.
2. The containers with sterilization solutions are labeled with the name of the solution and the date of activation and expiration and must be covered at all times. Daily and/or upon use monitoring of the solution efficacy is required.
3. Follow the manufacturer instructions for determining the expiration dates as solutions may vary. Regularly check the containers for evaporation loss of solution and replenish as necessary.

Hand Washing

1. Hand washing is the easiest and the most important measure to practice in the prevention of the spread of infection. While normal skin contains microorganisms of low virulence as resident flora, the transient flora acquired from other sources can be pathogenic. Hands are frequently implicated in the spread of infections. Hand washing practices have been shown to greatly reduce the spread of pathogenic flora.
2. All health care practitioners/staff will wash their hands:
   a. On arrival at work
   b. Before examining a patient
   c. After examining a patient
   d. Before performing invasive procedures, whether gloves are worn or not
   e. Before and after contact with any wound
   f. After contact with any source likely to be contaminated by pathogenic microorganisms.
   g. Before and after using the restroom.

Protective Clothing

1. Disposable gloves will be worn when handling all types of body fluids. When the handling of the body fluids is complete, remove the gloves in a manner so that the gloves are turned inside out. Dispose of the gloves in the appropriate receptacle and wash hands thoroughly.
2. In cases of possible contamination of employee clothing, a disposable gown should be worn. Dispose of the gown in the appropriate red-bag-lined bio-hazardous waste container and wash hands thoroughly.
3. Personal Protective Equipment (PPE), Goggles or face shields and water repellent, disposable gowns must be available to the staff for cases where projectile body fluids could be a possibility. After the procedure is complete, the goggles or shields are to be disposed of as bio-hazardous waste.

9.8: Medical Records

9.8.1: Policy

The onsite practitioner/provider audit is a comprehensive evaluation of the medical records. Through this process Blue Shield Promise Health Plan will identify areas of excellence and deficiencies based on approved criteria. Blue Shield Promise Health Plan will provide information, suggestions and recommendations to assist physicians in meeting and exceeding standards. All Primary Care Physicians will have a complete medical record review at each practice location, conducted in conjunction with the facility site review process. Blue Shield Promise Health Plan will utilize the current DHCS Medical Record Review tool to evaluate readiness and compliance with DHCS requirements – DHCS Policy Letter 14-004,or current version. Attachment B (see Facility Site Review Policy and Procedures https://www.blueshieldca.com/promise/media/pdf/providers/Facility_Site_Review_Policy_and_Procedures.pdf)

1. If the site, is a group practice the sample of medical records will be inclusive of all practitioners and determined by 1 to 3 Practitioners=10 charts; 4 thru 6 Practitioners=20 charts and 7 or more Practitioners=30 charts. If the facility is used by multiple practitioners that are not part of the same medical group, then the facility receives individual medical record reviews for each practitioner and 10 medical records will be reviewed for each practitioner.
2. The medical record review looks at your member records related to Format, Documentation, Continuity/Coordination of Care, Pediatric Preventive Care, Adult Preventive Care and if applicable OB/CPSP Preventive Care. Reviews are completed and Scoring of the medical record review will show The Certified Nurse reviewer will conduct the Medical Record Review in conjunction with the periodic Facility Review utilizing the most current approved Medical Record Review Tool. If this is an initial Medical Record Review, it will be a separate on-site review from the Facility Review and only medical records will be reviewed.

3. Staff from the FSR Department will arrange an appointment with the individual practitioner/ provider office. Blue Shield Promise Health Plan personnel are available to assist the practitioner/provider in preparation for the review and forms can be obtained from Blue Shield Promise Health Plan or from the Pre-Review packet that was received when the Facility Site Review was scheduled.
4. If the practitioner/provider is unwilling to schedule the medical record audit, the FSR Supervisors or QI Director will be notified. If arrangements cannot be made to complete this Medical record Review the practitioner panel may be closed to new members and the situation is referred to the QI Medical Director and the Credentialing Committee for further action which may include termination from the Blue Shield Promise Health Plan Network.
5. The Review Nurse, will review medical records, using the following rationale: passing or 80% total aggregate score or higher.
6. In order to ensure compliance with Blue Shield Promise Health Plan standards, Blue Shield Promise Health Plan will conduct follow-up audits of all practitioners/providers who score less than 80% overall, or in a section of their medical records audit, on their initial or routine medical record review.
7. Survey results will be utilized to conduct practitioner/provider education and as a component to the recredentialing process.

9.8.2: Procedure

1. Group Practice 1 thru 3 practitioners=10 records; 4 thru 6 Practitioners=20 records; 7 or more Practitioners=30 records. If more than 1 practice is using the same facility, then each independent practitioner will have 10 charts reviewed.
2. The FSR specialist will complete and score the medical record audit using the following ranges: 79% or lower is non-passing score; 80-90 % passing but requires a Corrective Action Plan; 90 thru 100% is an exempted pass and no Corrective action is required unless a section of the MRR scores below 80%.
3. If a corrective action plan is required, the reviewer will complete the corrective action plan at the time of the review and go over the deficiencies and corrective actions with the Practitioner and/or the office manager.
4. The practitioner/provider and/or office manager will sign the 1st CAP Notification Letter as verification of receipt of the completed review tool and Corrective Action Plan if applicable, and the nurse reviewer will supply a copy to the practitioner/provider/office manager.
5. If the nurse reviewer is unable to conduct provide a copy of the CAP at the time of the audit, all information will be mailed, faxed or emailed to the practitioner/provider.

6. The Provider will have 30 days from the date of the review to complete the corrective action plan and submit it to the Quality Improvement Department/Site Review unit at Blue Shield Promise Health Plan.
7. The Medical Record Review results will be maintained in the practitioner/ provider's FSR file.
8. The review results are accessed as needed by the Credentialing Department for the practitioner/provider's credentialing file.
9. When the CAP is received the review nurse will review the entire Corrective Action Plan and based on clinical knowledge and the document content will:
    a. Approve the CAP and place it in the practitioner/provider's FSR file and have a closure letter sent to the Practitioner.
    b. If it is not approved as submitted, the review nurse will indicate what is missing or inappropriate and the FSR Coordinator will request the missing information from the practitioner's office.
10. If the practitioner/provider's CAP is not received within 45 days, the FSR Coordinator will have a 2nd request letter sent to the practitioner giving an additional 2 days to submit the CAP.
11. If the practitioner/provider does not furnish the required documentation after the extended deadline, a third request may be sent. An unannounced visit may occur or a tandem audit with another contracted health plan may take place. If the CAP is not received the situation is referred to the QI Medical Director and the Credentialing Committee for further action which may include termination from the network.

9.8.3: Guidelines

Policy

A legible, detailed, well organized, confidentially stored, easily retrievable medical record will be maintained for each patient. These records shall be consistent with standard medical and professional practices, meet the standards of oversight organizations including Blue Shield Promise Health Plan, regulatory agencies, and the California Department of Health Care Services.

Procedure

1. The medical record is a legal document and should be treated as such.
2. The maintenance of the patient medical record is the responsibility of the individual practitioner/provider's office. The medical record should be secure and inaccessible to unauthorized persons in order to prevent loss, tampering, and disclosure of information, alteration or destruction of the record.
3. A patient's medical record should be easily retrievable at the time of the patient's encounter and for administrative purposes. To accomplish this, there should be a system for tracking the record. Records should be stored in one central location that is inaccessible to unauthorized persons.

4. Inactive medical records must remain accessible for a period of time which meets state and federal requirements (currently five years and to age of majority for minors). Patient medical records may be converted to microfilm or computer disks for long term storage.
5. Medical records must be destroyed in accordance with state and federal requirements. Every practitioner/provider of health care services who creates, maintains, preserves, stores, abandons, or destroys medical records shall do so in a manner that preserves the confidentiality of the information contained therein.
6. Entries must be legible to someone other than the author.
7. All entries must contain author identification. Signatures must include the first initial, full last name, and title. Initials are acceptable if the author can be identified in another manner.
8. Each page in the medical record must contain the patient's name and date of birth (an ID # may also be used).
9. Each chart must bear a label displaying the Member's name (last name, first name order) and date of birth (an ID # may also be used).
10. Blue Shield Promise Health Plan has designed a variety of medical record forms for practitioner/provider use. These forms have been designed specifically to satisfy Blue Shield Promise Health Plan and SDHS documentation standards.
11. All reports must be filed in the appropriate section of the record within 72 hours after receipt. 12. All consent forms must be filled out completely, including the date, time and signatures. If the
12. consent is completed by someone other than the patient (i.e., parent of a minor child), the relationship must be noted. Practitioner/Provider staff must witness all consent forms.
13. A chart is first prepared when a Member presents the first time for treatment or the PCP receives reports relating to the individual's treatment elsewhere.
14. If it is necessary to correct a handwritten entry, the person making the correction will line out the incorrect entry and sign and date the deletion. Do Not Use Whiteout or Other Products To Cover the Entry. Do Not Completely Black Out the Incorrect Entry.
15. Each form or other document must be securely placed in the appropriate section of the chart using fasteners. No loose papers or removable self-stick notes are to be in the chart; information on these items must be transferred to a progress sheet or other form.
16. Reports or other documents that are not on a standard size paper must be stapled or taped to an 8 1/2 x 11sheet and placed in the chart.
17. The medical chart is organized in specific sections. A six-section format, per the following table, is recommended:

Section 1. Patient Information (Inside the front cover)

1. Patient information sheet. This form should always be on top of all other forms in this section
2. The signed general consent for treatment and all other consent forms (e.g., IUD, sterilization, surgery, etc.) must remain in the chart and should be placed in this section
3. Authorization for release of medical records
4. Letters to and from the patient and/or his or her agent
5. Special cultural and linguistic needs

Section 2. History & Physical/Progress (First divider)

Adult charts:

1. Patient history/data base is/are the top forms in this section.
2. Problem List
3. Medication Flow Sheet
4. Immunization Flow Sheet
5. Hearing/Vision Screen Record
6. History and Physical Forms

Pediatric charts (if applicable):

1. CHDP Health Guidelines
2. Age Specific Assessment Form
3. Problem List Medication Flow Sheet
4. Medication Flow Sheet
5. Immunization Flow Sheet
6. Hearing/Vision Screen Record
7. Growth Charts
8. Lead Screening Questionnaire

Section 3. Laboratory

- Laboratory reports are to be filed in reverse chronological order with the most current data on the top
- Reports of a size that will not mount on the form should be taped to a regular piece of paper and filed on a mounting form

Section 4. XRAY and EKG

- File in reverse chronological order filing with EKG results segregated from each other

Section 5. Consult / Referral

- Referral information such as correspondence directed to an outside agency, physician, health facility, etc. regarding the medical information contained in his/her particular patient's medical record
- Copies of Requests for Referral/Consultation forms are filed in this section until the report is received, at which time the report is filed and the request is discarded
- Copy of medical records from previous medical practitioners/providers.
- Hospital discharge summaries
- Emergency room records

Section 6. Miscellaneous

- Correspondence with insurance companies or health plans
- Back to work forms
- Any reports, correspondence, forms, etc. that do not belong in another section
  a) If it becomes necessary to start a new volume, label the new chart "Vol. II of II" and label the old chart "Vol. I of II". The following items should be carried forward to Volume II:
  b) Consent to treatment form
  c) Problem Index
  d) Most recent history and physical form
  e) Pertinent history from previous practitioners/providers
  f) Most recent lab, x-ray, EKG and progress notes

Confidentiality

- All information contained in the medical record shall remain confidential. This includes medical, personal, social and financial information.
- Only authorized personnel (i.e., physicians, nurses, social workers, and authorized clerks) may have access to the contents of the medical record.
- Patient information in the medical record shall only be discussed over the telephone to facilitate patient care and only between qualified medical professional directly involved in the patient's care or health maintenance.
- Patient information in the medical record shall only be discussed by appropriate personnel and only in a location that assures confidentiality.
- Disclosure of patient medical records is discretionary in accordance with Sections 56.10 (Section 2) and 56.104 (Section 3) of the California Civil Code. Original patient medical records will not be removed from an office except under court order or under special arrangements with the physician's office.
- Patient information in a medical record may only be released under the following conditions:

a) The attorney or representative of the patient may receive a copy of the medical record after presenting a signed authorization from the patient or his/her representative. The patient must present identification when requesting a copy of his/her medical record. Outside health care practitioners/providers; federal, state, county or city agencies; employers; and insurance companies may also receive a copy of the patient record with the patient's authorization.
b) Any release in response to a court order or to authorized persons will be reported to the patient in a timely manner.
c) Member records may be disclosed, with or without patient authorization, to qualified personnel for the purpose of conducting scientific research; however, these records must not identify, directly or indirectly an individual patient in any report of the research or otherwise disclose participant identity in any manner to prevent divulging confidential information.
d) In accordance with individual provider agreements/contracts, health plan representatives are provided appropriate access to Member medical records for the purpose of quality review.

- Minors have the right to access confidential services without parental consent; therefore, those medical records and/or information regarding medical treatment specific to those confidential services are not to be released to the parent(s) without the minor's consent.
- Patient medical records may be transmitted to a requesting physician or facility via facsimile machines making sure that the transmission is confidentially directed and received. Due to the breakdown of fax paper, faxed materials not received on plain paper faxes must be photocopied prior to inclusion in the patient's record.
- Release of information must be documented in the patient's medical record. The documentation must include:
  a) The date and circumstances under which disclosure was made
  b) The names and relationships to the patient, if any, of persons or agencies to whom disclosure was made
  c) The specific information disclosed
- The supervisor of medical records assumes full responsibility for the Medical Records Department and all records.

Mental Health Care Records

1. Notwithstanding subdivision (c) of Section 56.10 of the California Civil Code, no practitioner/ provider of health care, health care service plan, or contractor may Release medical information to persons or entities authorized by law to receive that information pursuant to subdivision (c) of Section 56.10, if the requested information specifically relates to the patient's participation in outpatient treatment with a psychotherapist, unless the person or entity requesting the information or an authorized agent of the entity submits a signed request (See Appendix: 5 Sample: Authorization for Disclosure of Patient Healthcare Information Form). For the purpose of this policy, "psychotherapist" means a person who is both a "psychotherapist" as defined in Section 1010 of the Evidence Code and a "practitioner/ provider of health care" as defined in subdivision (d) of Section 56.05 of the Civil Code.
2. All requests for release of mental health information will include:
   a. The specific information relating to a patient's participation in outpatient treatment with a psychotherapist being requested.
   b. The specific intended use or uses of the information.
   c. The length of time during which the information will be kept before being destroyed or disposed of. (A person or entity may extend that timeframe, provided that the person or entity notifies the practitioner/provider, plan, or contractor of the extension.).
   d. A statement that the information will not be used for any purpose other than its intended use.
   e. A statement that the person or entity requesting the information will destroy the information and all copies in the person's or entity's possession or control will cause it to be destroyed or will return the information and all copies of it before or immediately after the length of time specified in paragraph 2(c) has expired.
3. All notifications of an extension of the timeframe in the original request will include:
   a. The specific reason for the extension
   b. The intended use or uses of the information during the extended time
   c. The expected date of the destruction of the information
4. The person or entity requesting the information will submit a copy of the written request to the patient within 30 days of receipt of the information requested, unless the patient has signed a written waiver in the form of a letter signed and submitted by the patient to the practitioner/ provider of health care or health care service plan waiving notification.
5. This policy and procedure does not apply to the disclosure or use of medical information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes, unless the disclosure is otherwise prohibited by law.
6. Nothing in this policy and procedure shall be construed to grant any additional authority to a practitioner/provider of health care, health care service plan, or contractor to disclose information to a person or entity without the patient's consent.

9.9: Access to Care

9.9.1: Access to Care Standards

Policy

Blue Shield Promise Health Plan will ensure that all primary care, specialty care, behavioral health, ancillary and other practitioners/providers, are in compliance with approved Access to Care Standards (See Appendix 7). Compliance with these standards is monitored through Member complaints and grievances, PQIs, Member Satisfaction Surveys, medical record reviews, disenrollments, PCP transfers and annual access surveys.

Procedure

1. Primary and specialty care physicians are required to be available to render emergency care to Members 24 hours a day, 7 days a week, either directly or through arrangements for after-hours coverage with an appropriately qualified practitioner/provider. Physicians may provide care in their offices or, based on the medical necessity of the case, refer the Member to an urgent or emergency care facility. Blue Shield Promise has a nurse on call to arrange for care if a practitioner/provider is unavailable. If a Member contacts the Plan about an emergency situation, the Plan will direct the Member to an appropriate urgent or emergency care center for immediate assessment and treatment. After-hours access issues will be referred to QI as a potential quality issue (PQI) and handled in accordance with approved procedures.
2. The Plan's Access to Care standards provide that no Member be required to travel any unreasonable distance or for any unreasonable period of time in order to receive covered services. For the purposes of these standards, "reasonable" is determined by analysis of the following factors:
   a. The population density of the geographic area traveled.
   b. Typical patterns of traffic congestion throughout the day.
   c. Established travel patterns in the community.
   d. Established patterns of medical practice in the community.
   e. Natural boundaries and geographic barriers to travel.
   f. Any other relevant factors.

   Attachments A, B, C, D, E and F provide accessibility standards for all network provider types.
3. The provider contract allows the Plan to monitor accessibility and requires contracted providers to abide by standards established for accessibility. The provider contract also specifically provides that Members will not be discriminated against with respect to physical accessibility to care. The provider will also ensure reasonable accessibility to emergency services, after hours coverage and minimal weekly availability for the provision of health care services.

4. The provider contract also mandates participation in the Plan's quality of care review program. Participation in the quality of care review program requires provider cooperation with the assessment of quality of care, accessibility and utilization patterns. The contracted provider agrees to take any appropriate remedial action deemed necessary by the Plan.
5. Access & Availability surveys are conducted at least annually using the Access to Care standards as a benchmark. Performance is measured for compliance with the guidelines. Standardized methodology appropriate for this type of survey will be used. Provider types as determined by established methodology are audited annually by the Plan.
6. Access & Availability survey results are reviewed by the Quality Improvement Department and the Quality Management Committee where opportunities for improvement are identified and discussed. Results and quality activities are reported to the BQIC. Results are communicated to individual providers and to delegated PPGs through performance notifications, JOCs newsletters, etc.
7. Selected interventions are implemented to improve performance. These may include written counseling and/or written corrective action plans for physicians not complying with the Access to Care standards. Continued non-compliance may result in referral to the Peer Review Committee for action up to and including termination. Interventions may also include global education for practitioners/ providers regarding the standards.
8. The effectiveness of the interventions is evaluated or re-measured. Additional telephone or mail surveys may be conducted to further evaluate a particular finding.
9. Access to care is also monitored and tracked through Member satisfaction surveys, Member complaints and grievances, potential quality of care issues, Member requested disenrollments and transfers, emergency room utilization and facility site reviews.
10. PPGs are expected to ensure that each practitioner/provider in their network receives and complies with the attached Access to Care standards.
11. Medi-Cal Laws requires organizations to ensure that the network providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to commercial enrollees. If the Provider serves only Medi-Cal recipients, hours offered to Medi-Cal manage care enrollee must be comparable to those for Medi-Cal fee-for service members.

9.9.2: Monitoring Process

The effectiveness of this policy will be monitored through oversight by regulatory agencies including DMHC, DHCS and accrediting entities. Effectiveness will also be measured annually through the annual access to care studies and annual quality improvement program evaluation.

9.10: Broken/Failed Appointments

9.10.1: Broken/Failed Appointment Follow-up

Policy

All practitioner/provider offices are required to have in place a procedure for scheduling appointments. Offices are also required to have a policy for assuring timely and efficient recall of patients who fail to keep scheduled appointments. The following is a sample "Broken/Failed Appointment" protocol which may be implemented by practitioner/provider offices if no other protocol is currently in place. Blue Shield Promise Health Plan will monitor its provider network for compliance via oversight activities that may include medical record review, provider surveys and/or review of provider policies.

Procedure

1. To assure timely and efficient recall of patients who fail to keep scheduled appointments. The primary care and/or specialty care practitioner/provider is responsible to:
   a. Determine daily whether and what type of follow-up is necessary.
   b. Document this decision in the patient chart, using a "Broken/Failed Appointment" rubber stamp. An example is provided here:

BROKEN/FAILED APPOINTMENTS

BROKEN APPT. DATE: _____

REVIEW DATE: _____

FOLLOW-UP REQ: _____

FOLLOW–UP ASAP: _____

NEW APPT. DATE: _____

PRACTITIONER/PROVIDER SIGNATURE: _____

COMPLETED BY: _____

2. At the end of each day the receptionist will determine which patients failed to keep their appointment by:
   a. Checking the appointment schedule and making a list of all failed appointments.
   b. Gathering the pulled charts which were ready for appointments (Charts are pulled the day before scheduled appointments).
3. Use a progress sheet with the latest date or a new progress sheet and stamp the sheet with the "Broken/Failed Appointment" rubber stamp.
4. Attach the progress sheet to the medical record and forward to the primary care practitioner/ provider.
5. The medical assistant (M.A.) or designated individual will review all charts of those patients who missed an appointment and wait for further orders from the

practitioner/provider.

6. The practitioner/provider will review the chart to determine the need for patient recall.
7. The practitioner/provider will complete items 2, 3 and 6 as needed, on the Broken/ Failed Appointment" rubber stamp, using the following guidelines:
   - Item 2 – Write in review data
   - Item 3 – Enter a checkmark if follow-up action is ordered
   - Item 4 – Enter a checkmark if the patient is to return to the clinic as soon as possible
   - Item 6 – Enter signature and title
8. If the patient needs follow-up, the M.A. or designated individual shall try to contact the patient
9. one time by phone. If no results, a recall postcard or letter will be mailed out to the patient's current address of record. A copy will be filed in the chart.
10. Every attempt to contact the patient, with date and time of each attempt, must be documented in the progress notes. Only the following staff may document patient recall activities in the medical record: M.D., P.A., N.P., R.N., L.V.N., or M.A.
11. The M.A. completes items 1, 5 and 7 as needed on the broken/failed appointment stamp using the following guidelines:
    - Item 1 – Enter the date of the broken appointment.
    - Item 5 – Enter the date of the new appointment.
    - Item 6 – Enter date, signature and title of person doing recall activity.
12. The broken/ failed appointment will also be documented in the appointment schedule for tracking purposes.
13. The practitioner/provider is responsible for final decisions concerning a broken/ failed appointment follow-up. Patients being followed for reportable conditions shall also be reported to the local health authority.
14. The administrator or office manager is responsible for:
    a. Assuring that all clinic personnel are aware of their responsibilities under this procedure.
    b. Designating, in conjunction with the Medical Director, the persons responsible for implementing this policy.
    c. Periodically monitoring the performance of staff in carrying out their duties.

9.11: Advance Directives

A primary care practitioner/provider is required to offer and/or educate each Member 18 years or older about advance directives. This must be documented in the medical record. The Member does not need to sign any advance directive but must be informed and educated about what an advance directive entails.

9.12: Clinical Telephone Advice

Policy

1. All telephone calls from patients with problems or medical questions must be documented (by date and time of call and return phone number) and promptly brought to the attention of the doctor.
2. At no time shall office personnel give medical advice without the direct involvement of the practitioner/provider or physician assistant.
3. The doctor must renew all prescriptions.
4. In the event a patient calls with a medical emergency, the patient will be instructed to call 911 immediately.
5. Medical groups that offer or contract with a company to offer telephone medical advice services must ensure that the service meets the requirements of Chapter 15 of Division 2 of the Business and Professionals Code, which include registration and monitoring.

Services which only direct patients to the appropriate setting for care (e.g., hospital or urgent care clinic) or prioritize physician appointments are not considered telephone medical advice services.

Blue Shield Promise Health Plan contracts with a certified vendor for after-hours Nurse Advice line.

9.13: HEDIS Measurements

Use of Practitioners/Providers Performance Data

Practitioners and Providers will allow Blue Shield Promise Health Plan to use performance data for quality improvement activities (e.g., HEDIS, clinical performance data). Blue Shield Promise Health Plan will also share Member experience & Clinical Performance data with Practitioners and Providers when requested. Requests should be submitted via email to your delegation coordinator.

Measure	Criteria	Description
1. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	Blue Shield Promise Health Plan will audit Members 18 – 64 years of age with a diagnosis of acute bronchitis who were not dispense an antibiotic prescription during the measurement year	The Member must have a date of service for any outpatient or ED visits during the intake period that meets all the following criteria: • Determine all acute bronchitis episode dates • Test for negative comorbid condition history • Test for negative medication history • Test for negative competing diagnosis

Measure	Criteria	Description
2. Asthma Medication Ratio (AMR)	Blue Shield Promise Health Plan will audit Members that are 5 – 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	The Member must be identified as having persistent asthma and have had administered oral medication, inhaler, injection, or intravenous dispensing for asthma. Identify members that have persistent asthma by a least four asthma medication being dispensed
3. Breast Cancer Screening (BCS)	Blue Shield Promise Health Plan will audit Members that are age 50–74 during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year.	The Member must have at least one (1) bilateral mammogram screen for breast cancer within the past two years.
4. Cervical Cancer Screening (CCS)	Blue Shield Promise Health Plan will audit female Members that are 21-64 years of age who were screened for cervical cancer	The Member who were screened for cervical cancer screening using either of the criteria: • Women 21-64 years of age who had cervical cytology performed every 3 years • Women 30-64 years of age who had cervical cytology/ human papillomavirus (HPV) co-testing performed every 5 years

Measure	Criteria	Description
5. Childhood Immunization Status (CIS)	The percentage of children 2 years of age who had DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and flu vaccines by their second birthday.	The Member must have the following immunizations by their second birthday: • 4 diphtheria, tetanus and acellular pertussis (DtaP) • 4 pneumococcal conjugate • (PCV) • 3 polio (IPV) • 3 haemophilus influenza type B (HiB) • 3 hepatitis B (HepB) • 1 measles, mumps, and rubella (MMR) • 1 chicken pox (VZV) • 1 hepatitis A (HepA) • 2/3 rotavirus (RV) • 2 influenza (flu)
6. Children and Adolescents' Access to Primary Care Practitioners (CAP)	The percentage of members 12 months – 19 years of age who had a visit with a PCP during the measurement year.	Members who had a visit with a PCP with the following criteria: • Children 12 – 24 months and 25 months – 6 years who had a visit with a PCP during the measurement year • Children 7-11 years and adolescents 12-19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year
7. Controlling Blood Pressure (CBP)	Blue Shield Promise Health Plan will audit Members that are Age 18 - 85 during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year.	Members who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year

Measure	Criteria	Description
8. Comprehensive Diabetes Care (CDC)	Blue Shield Promise Health Plan will audit Diabetic Members that are age 18-75 years of age during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year.	Diabetic Members must have the following done during the past year: • Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • HbA1c control (<7.0%) • Retinal eye exam performed • Medical attention for nephropathy BP control (<140/90 mm Hg)
9. Depression Screening and Follow-Up for Adolescents and Adults (DSF)	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.	The Member must have had the following: • Depression Screening: percentage of members who were screened for clinical depression using a standardized instrument • Follow-up on Positive Screen: percentage of members who received follow-up care within 30 days of screening positive for depression
10. Immunization for Adolescents (IMA)	Blue Shield Promise Health Plan Members that are 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	Members must have the following immunizations completed by their 13th birthday: • At least one meningococcal vaccine on or between the member's 11th and 13th birthday • At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine on or between the member's 10th and 13th birthday • At least two HPV vaccines with different dates of service on or between the member's 9th and 13th birthday

Measure	Criteria	Description
		• There must be at least 146 days between the first and second dose of HPV vaccine • OR at least 3 HPV vaccines with different dates of service on or between the member's 9th and 13th birthday
11. Annual Monitoring for Patients on Persistent Medication (MPM)	Blue Shield Promise Health Plan Members that are 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy and one therapeutic monitoring event for the therapeutic agent in the measurement year.	Members that have received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB). Annual monitoring for members on diuretics.
12. Use of Imaging Studies for Low Back Pain (LBP)	Blue Shield Promise Health Plan members with a primary diagnosis of low back pain who did not have an imaging study within 28 days of the diagnosis during the measurement year	The Member that have had a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan).
13. Prenatal Care (PPC)	Blue Shield Promise Health Plan will audit women age 16 to 24 years of age who are sexually active. Must be continuously enrolled during the measurement year with no more than a one-month gap in enrollment.	The Member must have at least one (1) chlamydia test performed during the measurement year.
14. Well Child Care 3, 4, 5, 6 Years of Age (W34)	Blue Shield Promise Health Plan will audit Members that have turned three, four, five or six years old during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year.	The Member must have at least one (1) well child visit during the measurement year. Must have evidence of the following: • Mental and developmental history • Physical examination Health education/ anticipatory guidance • Health history

Measure	Criteria	Description

15. Wight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)	Blue Shield Promise Health Plan Members that are 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and physical activity	Members that have had an outpatient visit with a PCP or OB/ GYN during the measurement year with the following documented:
		• BMI percentile
		• Counseling for nutrition
		  • Discussion of current nutrition behaviors
		  • Checklist indicating nutrition was addressed
		  • Counseling or referral for nutrition education
		  • Anticipatory guidance for nutrition
		  • Weight or obesity counseling
		• Counseling for physical activity
		  • Discussion of current physical activity behaviors
		  • Checklist indicating physical activity was addressed
		  • Counseling or referral for physical activity
		  • Anticipatory guidance specific to the child's physical activity
		  • Weigh tor obesity counseling

9.14: Credentialing Program

Purpose

To ensure that all network practitioners/providers meet the minimum credentials requirements set forth by Blue Shield Promise and the regulatory agencies including, but not limited to, the NCQA, DHCS, DMHC, and other regulatory agencies for participation in the network. At least every three (3) years, the practitioners/providers are required to undergo recredentialing to ensure that they are in compliance with these standards.

Scope

The credentialing program applies to all direct-contracted and delegated practitioners, who are affiliated with Blue Shield Promise through their relationship with a contracted PPG. Blue Shield Promise requires the credentialing of the following independent contracted practitioners: physicians (MD, DO), podiatrists (DPM), oral surgeons (DDS, DMD), optometrists (OD), and mid-level practitioners/ providers (PA, NP, CNS and NMW) employed in these practitioner's offices and see Blue Shield Promise members. Blue Shield Promise and its delegates may also credential other allied health professionals, such as psychologists (PhD, PsyD), audiologists (AU), registered dietitians (RD), and other practitioners authorized by law to deliver health care services and contracted by Blue Shield Promise on an independent basis.

Blue Shield Promise does not credential hospital-based practitioners (i.e. radiologists, anesthesiologists, pathologists, and emergency medicine physicians) who practice exclusively in an inpatient setting and provide care of Blue Shield Promise members because Blue Shield Promise members are directed to the hospital.

Objectives

- To ensure that all practitioners/providers, including both direct-contracted and delegated, who are added to the network meet the minimum Blue Shield Promise requirements.
- Blue Shield Promise practitioners/providers are evaluated for, but not limited to, education, training, experience, claims history, sanction activity, and performance monitoring.
- To ensure that network practitioners/providers maintain current and valid credentials.
- To ensure that network practitioners/providers are compliant with their respective state licensing agency and Medi-Cal programs, and Blue Shield Promise has a process to ensure that appropriate action is taken when sanction activity is identified.
- To establish and maintain standards for credentialing and to identify opportunities for improving the quality of practitioners/providers in the network.

Credentialing Policies and Procedures

Policies and procedures are reviewed annually and revised as needed to meet the NCQA, DHCS, DMHC, CMS, state and federal regulatory agencies' requirements. Policies and procedures are reviewed by the Chief Medical Officer and submitted to the Credentials Committee and Compliance Department for review and approval.

Credentials Committee

The Credentials Committee is responsible for overseeing the credentialing and recredentialing of all practitioners/providers contracted with Blue Shield Promise. The CMO serves as chairman of the Credentials Committee, which is comprised of a multi- specialty panel of practitioners/providers in the Blue Shield Promise network,

the Credentialing Manager and any additional physicians as needed, for their professional expertise. However, only physicians have the right to vote in Credentials Committee Meeting. A minimum of three (3) voting Members is considered a quorum. The Credentials Committee meets at least once a month but not less than quarterly. If there is a need, committee will conduct an ad-hoc meeting.

The responsibilities of the Credentials Committee include but are not limited to:

- Review, recommend, and approve/deny initial credentialing, recredentialing, ongoing monitoring activities and inactivation of direct-contracted practitioners/providers for the Blue Shield Promise network;
- Review and approve credentialing policies and procedures and ensure they are in compliance;
- Review and recommend actions for all network practitioners/providers identified with sanction activities from the state licensing agency, Medi-Cal suspended list, SAM, CHHS (MediCal Enrollment) and OIG;
- When there is a quality deficiency, appropriate authorities were reported; and
- Fair Hearings are offered and carried out in accordance to the established policies and procedures.

9.14.1: Minimum Credentials Criteria

All practitioners will be credentialed and recredentialed in accordance to the approved policies established by Blue Shield Promise.

1. All applicants will meet the following minimum credentialing requirements and submit a comprehensive profile sheet to include:
    a. Name
    b. Professional Title
    c. Office Address
    d. Telephone & Fax Numbers
    e. Office Hours
    f. Provider Type (PCP/Specialist)
    g. Specialty with Board Certification Status or Complete Internship/Residency Training
    h. Languages Spoken by Provider and Staff; includes American Sign Language
    i. Non-English languages spoken by qualified medical interpreter
    j. California Medical License Number. Must hold and maintain a current and unrestricted State medical or professional license.
    k. Hold a current and valid DEA certificate, if applicable.
    l. Tax Identification Number
    m. National Provider Identifier (NPI)

n. Maintain current hospital privileges in the requested specialty at a Blue Shield Promise contracted hospital. This requirement may be waived only if the physician arranges for another Blue Shield Promise practitioner/provider to provide hospital coverage at a contracted hospital. This arrangement must be documented in writing by the covering physician and submitted to Blue Shield Promise. Exception to this requirement is granted to specialties that do not typically require admitting privileges (i.e., dermatology, pathology, radiology, psychology, and optometry)

o. Initial Approved/Recredentialed Date

p. Birth Date

q. Medi-Cal Number

r. Gender

s. Ethnicity

t. Panel Status:
   - 1. Accepting new patients
   - 2. Accepting existing patients
   - 3. Available by Referral only
   - 4. Available only through a hospital or facility; or
   - 5. Not accepting new patients

u. Email address; if permitted by provider via written communication

v. FQHC or Clinic name

w. If applicable, website URL for each service location

x. Maintain current and valid malpractice insurance in at least a minimum coverage of $1 million per occurrence and $3 million annual aggregate (Optometrists and audiologists are required to have minimum malpractice coverage of $1 million per occurrence and $2 million annual aggregate).

y. Meet minimum training requirements for the requested specialty. The applicant must have no mental or physical conditions that would, with reasonable accommodation, interfere with his/her ability to practice within the scope of the privileges requested.

z. Be eligible to participate in the Medi-Cal program with no sanctions. The enrollment and screening must be verified through Medi-Cal enrollment site.

aa. Have no felony convictions.

bb. Be able to provide coverage to Members, either personally or through appropriate physicians 24 hours per day, seven (7) days per week.

cc. Agree to abide by Blue Shield Promise policies and procedures.

dd. PCPs are required to have a passing score on the facility site review and medical record review.

2. All applicants will meet the following minimum training requirements: Physicians (MD, DO) must be either:
   - Board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty boards;

- Board qualified with the ABMS or AOA by having completed the requisite residency or fellowship required by the particular Board; or
- A practitioner who has satisfactorily completed an Accreditation Council for Graduate Medical Education (ACGME) accredited internship prior to the establishment of the Family Practice Board in 1969 and had been in practice full time since may be "grandfathered" into Family Practice.

aa. A specialist provider applying as primary care provider must complete at least one- year stateside training in primary care medicine (Internal Medicine or Family Practice);

bb. A primary care provider applying as a specialist must complete at least one year of specialized training (not in primary care medicine) in United States and provide two letters of recommendation from other primary care physicians.

cc. An OB/GYN requesting PCP status must have completed at least one year of stateside primary care medicine. If an OB/GYN has completed at least one year of specialized training (not in primary care medicine) in the United States and he/she may substitute two (2) letters of recommendation from other primary care physicians for one year of primary care training.

dd. The physician has completed an International Medical Graduate (IMG) training program and has completed a Canadian or British Isles residency program. (The ABMS formally recognizes Canadian and British medical schools and residencies as equivalent to US training but does not recognize Canadian and British Specialty Boards).

ee. Podiatrists (DPM) are required to be either board certified by a Board recognized by the American Podiatric Medical Association (e.g., American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) and American Board of Podiatric Surgery (ABPS)) or completed a podiatric residency program or doctorate in podiatric medicine.

ff. Optometrists (OD) are required to complete a professional degree in Optometry.

gg. Oral Surgeons (DDS, DMD) are required to have completed a professional degree in dentistry.

hh. Physician assistants (PA), nurse practitioners (NP), clinical nurse specialist (CNS) and nurse mid- wives (NMW) must have successfully completed the academic program required for the requested status. For example, a nurse practitioner must have completed a nurse practitioner academic program.

ii. Allied health professionals are required to have successfully completed the professional program required for their requested specialty.

jj. The HIV specialist must meet any one of the following four criteria:

- Credentialed as an "HIV Specialist" by the American Academy of HIV Medicine.
- Board certified in HIV medicine by a Member board of the American Board of Medical Specialties.
- Board certified in Infectious Disease and meets the following qualifications:
- Meets the following qualifications:
  - In the immediately preceding 12 months, has provided continuous and direct medical care to a minimum of 24 patients who are infected with HIV.
  - In the immediately preceding 12 months, has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year.
- Meets the following qualifications:
  - In the immediately preceding 24 months, has provided continuous and direct medical care to a minimum of 20 patients who are infected with HIV.
  - Has completed any of the following:
    i. In the immediately preceding 12 months, has obtained board certification or recertification in infectious disease.
    ii. In the immediately preceding 12 months, has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients.
    iii. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

kk. The HIV specialist may utilize the services of a nurse practitioner or physician assistant if:

- The nurse practitioner or physician assistant is under the supervision of an HIV specialist.
- The nurse practitioner or physician assistant meets the qualifications specified above.
- The nurse practitioner or physician assistant and the supervising HIV specialist have the capacity to see an additional patient.

The Credentialing Committee may consider other exceptions as it deems necessary and/or appropriate. The Chief Medical Officer may recommend the acceptance of an applicant even if the practitioner/provider does not satisfy minimum criteria if there is a determined need and if there is credible evidence that the practitioner/provider is capable of providing the services requested.

Recredentialing

At least every three (3) years, a practitioner/provider must be recredentialed in order to maintain his/her membership with Blue Shield Promise. Six months prior to the recredentialing due date, Credentialing Department will mail out a pre-print recredentialing application to the practitioner/provider for review. The practitioner/provider will be instructed to review and update the application with current information, complete an attestation questionnaire, sign, date the appropriate pages, and return it with the supporting documentation as required to the Credentialing Department. A cover letter stating that failure to return the recredentialing application by its deadline may be considered a voluntary resignation by the practitioner/provider. Upon receipt of a completed recredentialing application, the Credentialing Department will follow its procedures in processing the application for recredentialing. If the recredentialing application is not received by Blue Shield Promise Credentialing Department by the given timeframe, a follow- up for recredentialing will be mailed to the practitioner/provider. A final follow- up will be sent to practitioners/providers who have not returned their applications after 90 days from the initial mailing. The Contracting Department will be notified of the practitioners/ providers who are non-responsive to the recredentialing requests and will follow their procedures for appropriate action, including administrative termination for non-compliance.

Credentialing Time Limit

The credentialing and recredentialing documents must be within 180 calendar days prior to the Credentialing Committee decision.

9.14.2: Credentials Process for Participating Provider Group "PPG"

PPGs that are delegated for credentialing activities are required to credential and recredential practitioners/providers, mid-level practitioners/providers and non- physician practitioners/providers in accordance with the above Blue Shield Promise policies and procedures, NCQA, DHCS, DMHC guidelines and applicable federal and state laws and regulations. Recredentialing is required at least every three (3) years.

Blue Shield Promise retains ultimate responsibility and authority for all credentialing activities. Blue Shield Promise will assess and monitor the PPG's delegated credentialing activities as follows:

1. The Credentialing Delegation Oversight Auditor will conduct pre-contractual and annual onsite audits in accordance with the Delegated Oversight Policy and Procedure. The audit will include a review of the PPG's policies and procedures, Credentialing Committee minutes, ongoing monitoring, quarterly

reports and the PPG's credentials files. The standardized audit tool (Appendix C) will be used to conduct the audit. The PPG will be required to submit a complete credentialing roster, with specialty, credentialing and recredentialing dates, and board certification name and expiration date , at least two (2) weeks prior to the scheduled audit date.

2. Blue Shield Promise will use one of the following techniques for the file review: Blue Shield Promise pre-delegation or annual audits will have their credentialing files reviewed based on the NCQA's 8/30 Rule. Prior to the audit, the Blue Shield Promise auditor will provide a list of 30 initial files and 30 recredentialed files to be reviewed at the audit to the PPG. The Blue Shield Promise auditor will audit the files in the order indicated on the file pull list. If all eight (8) initial files are compliant with all the required elements, the remaining 22 reserve initial files will not have to be reviewed. If any of the first eight (8) files are scored non- compliant for any required element, then the auditor will need to review all 30 initial files. After completion of the initial file review, the auditor will follow the same procedure for the recredentialed files review.
3. PPG will be required to sign and abide by the credentialing delegation agreement, which is attached to the capitated group agreement.
4. To be delegated and to continue delegation for credentialing, PPGs must meet the minimum standards by scoring at least 95%. If the PPG scored below 95%, a corrective action plan (CAP) is required. PPG must submit all deficiencies to Blue Shield Promise Credentialing Delegation Oversight Department within 30 days of notification is received. After reviewing the CAP, the PPG will be sent a letter noting acceptance of the CAP or any outstanding deficiencies.

The Credentialing Delegation Oversight Department will ensure the CAP meets all regulatory requirements.

1. Delegated credentialing status may be terminated by Blue Shield Promise at any time in which the integrity of the credentialing or recredentialing process is deemed to be out of compliance or inadequate.
2. Blue Shield Promise retains the right to approve, suspended and terminate practitioners/ providers or sites based on issues with quality of care.
3. Delegated PPGs are required to submit a quarterly report for practitioners/ providers credentialing, recredentialing, termination and suspension activities.
4. The PPG is required to review all Blue Shield Promise practitioners/providers sanction activities within the 30 days of the report issued date and report the finding to Blue Shield Promise as Blue Shield Promise practitioners/providers are identified.

5. The PPGs is responsible to provide and assist any credentials document needed for investigation and audit which include but not limited to specific information related to a provider's training, action related to any sanctions, etc.

6. The PPG is required to submit copies of originals files for selected practitioners/providers at the time of regulatory agency oversight audits or at any time requested by the health plan for regulatory oversight audit.

Credentials Process for Directly Contracted Physicians

- The Credentials Committee is responsible for making decisions regarding initial credentialing, recredentialing, and changes to credentials, and inactivation of all direct-contracted practitioners/providers.
- Blue Shield Promise has adopted the California Participating Physician Application (CPPA), or CAQH applications.

1. Reasons for inability to perform the essential functions as a provider, with or without accommodation.
2. Lack of present chemical dependency or substance abuse, including illegal drugs.
3. History of loss of license and felony convictions.
4. History of loss or limitations of privileges or disciplinary activities.
5. Attestation regarding the correctness and completeness of the application.

- In addition to completing an initial application, the practitioner must provide:
- A copy of his/her current professional license to practice.
- A copy of a current and valid DEA certificate (if applicable).
- A copy of a current malpractice insurance certificate with the practitioner listed as an insured with the minimum required coverage.
- A current curriculum vitae (CV). (include month and year)
- A copy of the ECFMG certificate (if applicable).
- A written explanation regarding any sanction activity, malpractice judgments in the last five (5) years or pending claims, restriction of privileges, etc.

Upon receipt of a completed application, Blue Shield Promise will obtain and verify the information in accordance to its policies and procedures. Information, unaccompanied by all the supporting documentation, dated more than three months prior to receipt, etc.) is received, the Credentialing Department will contact the applicant for the missing information. Failure to submit the information within after the third attempt will be considered a voluntary withdrawal of the application.

An initial facility site review/medical record review of all PCP offices are required prior to inclusion into the Blue Shield Promise network. This will be a structured visit, in accordance with the QI facility site review and medical record procedures. The FSR must be conducted prior to initial credentialing decision and every three (3) years thereafter.

Upon completion of the credentialing verification process, a report summarizing each applicant's credentials is forwarded to the Credentials Committee for review and action. If the Committee recommends denial, limitation, suspension, or termination of Membership based on a medical disciplinary cause or reason, the practitioner shall be entitled to a formal hearing pursuant to the Fair Hearing policy. The Fair Hearing policy does not apply to mid-level practitioners.

A report of the Credentialing activity is forwarded to the Quality Management Committee for approval. The Credentialing Committee's approval date is considered as the final credentialing approval date.

The Credentialing Department notifies the Contracting Department or the Promise Provider Relations (PPR) for credentialing activities on monthly basis. The monthly distribution includes a practitioners/providers listing and practitioner/ provider profiles. The Contracting Department and PPR will follow their procedures for executing the contract and adding the practitioner/provider to the network.

Practitioners/Providers' Rights

Practitioners/Providers shall have the right to:

- Review all non-protected information obtained from any outside source in support of their credentialing applications, except references or recommendations protected by peer review laws from disclosure.
- Respond to information obtained during the credentialing process that varies substantially from the information provided by the practitioner/provider.
- Correct erroneous information supplied by another source during the
- credentialing verification process.
- Practitioners will be notified of their rights in the initial and recredentialing application packet.

Confidentiality of Credentials Information

All information related to credentialing and recredentialing activities is considered confidential. All credentialing documents are kept in locked file cabinets in the Credentialing Department, which is kept locked when not occupied. Only authorized personnel will have access to credentials files. Practitioners/Providers may access their files in accordance with the established policies. All confidential electronic data will be access-controlled through passwords. Access will be assigned based on job responsibility, and also on a need-to-know basis. All Credentials Committee Members, guests, and staff involved in the credentialing process will sign a confidentiality agreement at least annually.

Sanction Review

Blue Shield Promise queries the National Practitioner Data Bank, Office of Inspector General, Medi-Cal S&I, SAM and state licensing agencies at the time of initial and recredentialing to determine if there have been any sanctions placed or lifted against a practitioner/provider. Documentation regarding the identified sanction is requested

from the agency ordering the action. If the affected practitioner/provider is contracted directly with Blue Shield Promise, then the practitioner/provider is notified in writing of the action and requested to provide a written explanation of the cause(s) for the sanction and the outcome. If the practitioner/provider is delegated to a PPG, then the affected PPG is notified of the sanction activity in writing and requested to provide a written plan of action. This information, along with the documentation and the PPG's response, is forwarded to the Credentials Committee for review and action.

Blue Shield Promise also monitors the practitioner for license, DEA and malpractice insurance expiration dates. On a monthly basis, the Credentialing Department runs a report for the medical/ professional license, DEA, and malpractice insurance due to expire within the following month.

License renewals are verified with the licensing board within 30 days of the expiration date. The DEA renewals are verified from the National Technical Information Service (NTIS) or by an updated copy from the provider. Malpractice insurance renewals are verified by an updated copy of the certificate from the provider.

Summary Suspension of a Practitioner's Privileges

- Immediate action will be taken to suspend a practitioner's privileges in the event of a serious adverse event. A serious adverse event is defined as any event that could substantially impair the health or safety of any Member.
- Immediate action will also be taken to suspend a practitioner's privileges in the event the practitioner fails to meet the following minimum credentialing criteria:
    1. The practitioner's license to practice has been revoked, suspended, or under any type of restriction or stipulation, including probation, by the state licensing agency.
    2. The practitioner has been suspended from the Medi-Cal program; however,
    3. this does not apply to practitioners who participate in only in the Medicare program.
    4. The practitioner fails to maintain the minimum malpractice liability coverage.
- Should a practitioner/provider fail to meet the minimum credentialing criteria as described above, Blue Shield Promise will allow the practitioner/provider a chance to correct the deficiency before inactivating the practitioner/provider. Upon knowing that a practitioner/ provider is noncompliant, the Credentialing Department will notify the practitioner/provider immediately in writing of the deficiency. The notification will specify the methods available for correcting the deficiency and the timeframe allowed for the submission, and that failure to correct the deficiency will result in immediate inactivation.
- Any information regarding an adverse event will be forwarded to the QI Department as a potential quality issue (PQI) and handled in accordance with the established policies and procedures.

- The Chief Medical Officer has the authority to immediately suspend any or all portions of a practitioner's privileges in the event of a serious adverse event (as defined above). The written notice will include a notice of the practitioner's right to a Fair Hearing. (Please refer to Policy
- 70.1.3.10 Fair Hearing Plan for detail)
- A summary suspension of a practitioner's membership or employment is imposed for a period in excess of fourteen (14) days.
- The notice of suspension shall be given to legal department for ratification. In the event of suspension, the practitioner's members shall be assigned to another practitioner. The wishes of the patient shall be considered, where feasible, in choosing another practitioner.

Blue Shield Promise will adhere to the California Business and Professional Codes requirements for submitting 805 and 805.01 reports to the Medical Board of California and to the Healthcare Quality Improvement Act of 1986 for reporting to the National Practitioner Data Bank and to the State Medical Board.

Health Delivery Organizations

Prior to contracting with, and at least every three (3) years thereafter, Blue Shield Promise will re- evaluate health delivery organizations (HDO) such as hospitals, home health agencies, skilled nursing facilities, and nursing homes to ensure they have appropriate structures and mechanisms in place to render quality care and services. The evaluation process includes confirmation of the following:

- In good standing with the state and federal regulatory bodies.
- Current accreditation by a Blue Shield Promise recognized accrediting bodies.
- If the HDO is not accredited, the Blue Shield Promise facility site review, CMS or DHHS survey is required.

SECTION 10: PHARMACY AND MEDICATIONS

10.1: Drug Formulary Policy

Blue Shield Promise Health Plan members shall have access to FDA-approved drugs that are medically necessary via the drug formulary or prior authorization and exceptions procedures. In order to ensure Members receive high quality, cost-effective and appropriate drug therapy, Blue Shield Promise Health Plan will maintain drug formularies consistent with the required pharmacy benefit design for all contracted product lines. The formularies will be maintained by the Blue Shield of California Pharmacy & Therapeutics (P&T) Committee.

Procedure

1. The P&T Committee is responsible for periodically reviewing and amending the drug formularies at least once a year.
2. The Medi-Cal drug formulary will include, at a minimum, representative drugs in every therapeutic category or class listed on the Medi-Cal Fee for Service (FFS) Contract Drug List (CDL), including non-legend and over-the-counter (OTC) drugs, shall be represented by at least one (1) drug on Blue Shield Promise Health Plan's formulary within six (6) months of its inclusion. Therapeutic category or class is defined by the American Hospital Formulary Service or United States Pharmacopeia therapeutic classification system. The formulary will meet DHCS comparability requirements as defined by All Plan Letter 16-010. Formulary will be submitted to DHCS and LA Care annually for review. If all drugs within the same therapeutic category require a prior authorization, Blue Shield Promise Health Plan will submit clinical rationale and criteria to be used for evaluation. Blue Shield Promise Health Plan can use utilization controls, including but not limited to, Prior Authorization, Step Therapy, Quality Limits, and Duration of therapy, but will not impose prior authorization related to emergency care, family planning, preventive services, basic prenatal care and sexually transmitted disease. Members will have access to all drugs on the fee-for-service (FFS) contract drug list (CDL) either as a formulary benefit or thru the exceptions process for Non-Formulary drugs.
3. Additionally, the Medi-Cal formulary will include the ACIP (Advisory Committee on Immunization Practices)-recommended adult immunizations, which are also found on the Medi-Cal fee-for-service (FFS) contract drug list (CDL). No prior authorizations will be imposed on these ACIP-recommended adult vaccines. With the administration of certain immunizations that are subject to further clinical criteria, treatment authorization guidelines will adhere to the least restrictive ACIP or Medi-Cal Provider Manual recommendations available. In the event that the Food and Drug Administration (FDA) approves any vaccine for childhood immunization prior to final ACIP recommendations, Blue Shield Promise Health Plan will consider coverage of the vaccine on a case by case basis (regardless of vaccine coverage under the Vaccines for Children program).

4. Furthermore, the Medi-Cal formulary will cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee by a qualified provider/pharmacist.
5. The Medi-Cal drug formulary will not include medications carved out to Medi-Cal FFS, such as (but not restricted to) antipsychotic, HIV, or prescribed end of life/aid-in-dying medications. Additionally, the formulary will not contain classes of medications excluded from the Medi-Cal program altogether, such as (but not restricted to) drugs used for fertility, cosmetic purposes/ hair growth, erectile dysfunction, or vitamin or minerals used for dietary supplementation.
6. Blue Shield Promise Health Plan drug formularies will indicate which pharmaceuticals require prior authorization. Any limitations on quantities, the number of refills, dosage or length of therapy will be noted.
7. Step Therapy: In some cases, Blue Shield Promise Health Plan will require that the patient has a trial of a first-line medication, prior to approving a second-line medication.
8. Therapeutic interchange: Is the practice of offering clinically appropriate, cost effective formulary alternatives. This includes generic substitutions when there is a generic version of a brand-name drug available, our network pharmacies will automatically dispense the generic version, unless the prescription indicates "brand only." If an FDA-approved generic alternative is available on the Blue Shield Promise Health Plan formulary, the prescribing physician will need to submit medical justification for the use of the brand product. Blue Shield Promise Health Plan will work with the prescribing physician to get this accomplished.
9. Any provider may request the P&T Committee to consider an addition, deletion or modification to the drug formularies. Requests must be made in writing to the Chief Medical Officer (CMO). The Blue Shield Promise Health Plan pharmacists are responsible for researching all requests and submitting information and a recommendation to the P&T Committee.
10. The P&T Committee considers all requests for formulary changes at its regular quarterly meeting. The committee will take into account at a minimum the safety, effectiveness, efficacy and cost when considering a change to the formularies.
11. Providers and pharmacies will be notified of all formulary changes, including restrictions and preferences, via newsletter or special notice. The newsletters will reference the Blue Shield Promise Health Plan website which maintains updated formularies/formulary search capabilities.
12. Providers may access the drug formularies at any time on the Blue Shield Promise Health Plan website at https://www.blueshieldca.com/promise. The Medi-Cal formulary will be updated and posted on a monthly basis on the Blue Shield Promise Health Plan website. Formularies will be provided to all Blue Shield Promise Health Plan PCPs and will be made available upon request to all network

providers and Members. Members are informed of the availability of the formulary upon enrollment and annually. Notices of their availability will be included in the Member Service Handbook, Provider Manual, newsletters and/or special notices. The formulary will provide an explanation of limits and quotas, along with step-therapy protocols.

13. The formularies, in their entirety, will be reviewed at least annually by the P&T Committee. The review may be divided into drug categories.
14. All formulary changes will be submitted to the appropriate regulatory agency.
15. Non-formulary drugs that are deemed medically necessary are available through the prior authorization or exception review process.
16. Members will be provided an evidence of coverage (EOC) handbook annually and upon enrollment, which will explain what a formulary is, and the pharmaceutical management procedures. The EOC will also contain information explaining Blue Shield Promise Health Plan's process for generic substitution and therapeutic interchange. Practitioners will be made aware of pharmaceutical management procedures, including generic substitution, therapeutic interchange, and step-therapy protocols, via the Blue Shield Promise Health Plan website and newsletters. The Blue Shield Promise Health Plan website will also communicate to the prescribing practitioners of how they can provide information to support an exception request.

Review of medication requests for non-FDA approved indications:

1. In accordance with Section 1367.21 of the Health and Safety Code, Blue Shield Promise Health Plan will not limit or exclude coverage for a drug on the basis that the drug prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
    a. The drug is approved by the FDA;
    b. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition or the drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the Blue Shield Promise Health Plan formulary. If the drug is not on the Blue Shield Promise Health Plan formulary, the participating subscriber's request shall be processed as a non-formulary drug request in accordance with the appropriate policies and procedures. (Refer to Prior Authorizations and Exceptions in section 10.3); and
    c. The drug has been re cognized for treatment of that condition by one of the following:
        - Elsevier Gold Standard's Clinical Pharmacology.

- American Hospital Formulary Service Drug Information.
- Thompson Micromedex DRUGDEX.
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium for chemotherapy and biologic agents.
- Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

2. It shall be the responsibility of the participating prescriber to submit to Blue Shield Promise Health Plan documentation supporting compliance with the above-mentioned requirements when requested by the plan.
3. Criteria utilized in the review of a prior authorization request for an FDA approved drug utilized for a non-FDA approved indication will include, at a minimum, the following:
    a. Submission of the required medical information
    b. Contraindications or previous treatment failures with FDA approved medications that have FDA approved indications for the intended use of the requested medication.
4. Any coverage required by this section shall also include medically necessary services associated with the administration of a drug, subject to the conditions of the contract.
5. For purposes of this section, "life-threatening" means either or both of the following:
    a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
    b. Diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.
6. For purposes of this section, "chronic and seriously debilitating" means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.
7. The provision of drugs and services when required by this section shall not, in itself, give rise to liability on the part of Blue Shield Promise Health Plan.
8. Nothing in this section shall be construed to prohibit the use of a formulary, co-payment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

10.2: Continuity of Care for Medications

Policy

Newly enrolled Members with certain conditions who have been on an established medication that is not on the current formulary will have uninterrupted access to that medication. A new Member with prescriptions for specific conditions will not be denied a refill until the Member has been given an opportunity to be seen by his/her PCP.

Procedure

1. When new Blue Shield Promise Health Plan Members, or their pharmacies, request either refills or new prescriptions for ongoing treatment involving the medications for specific conditions listed below, Blue Shield Promise Health Plan will assure treatment is not interrupted by implementing one of the following procedures:
    a. Assuring the provision of an appointment prior to the time the prescription is exhausted.
    b. Assuring the provision of limited refills or new prescriptions by the PCP or the specialist designated as the care alternate.
2. The following medications and conditions are covered under this policy:
    a. Anti-hypertensives
    b. Diabetic medications and supplies
    c. Antiasthma medications
    d. Anticonvulsants
    e. Other medications/conditions evaluated on an individual basis and determined to be medically necessary for an immediate prescription refill and any other drug utilized for a chronic condition.
3. For members newly enrolled to Blue Shield Promise Health Plan, the continued use of a single- source drug(s) as part of a prescribed therapy in effect for the member immediately prior to the date of enrollment will be allowed if continuity of care can in fact be established

10.3: Prior Authorizations and Exceptions

Most medications on the formulary are covered without prior authorization. However, some medications require the patient's prescription and medical history to establish medical necessity and to evaluate use of preferred, formulary alternatives prior to coverage.

Medications not covered on the formulary or that are prescribed outside of coverage rules require an exception for coverage based on medical necessity. Types of exceptions include:

- Formulary exceptions. Coverage of a non-formulary (non-listed) drug when formulary alternatives are not appropriate for the individual patient.
- Waiver of coverage restrictions or limits, such as prescription quantity limits or step therapy protocols for prior use of preferred drugs.

- Specialty pharmaceuticals, as defined by AB2420.

If a drug is not listed in the Blue Shield Promise Health Plan formulary or requires a prior authorization, the prescriber or member may contact Blue Shield Promise Health Plan formulary Member Services to confirm the drug's coverage status.

If Member Services confirms that the drug is not part of the Blue Shield Promise Health Plan formulary and not covered, the member has two options:

- The member can ask the prescriber to prescribe a different drug, one that is part of the Blue Shield Promise Health Plan formulary.
- The member can request that Blue Shield Promise make a Formulary Exception (a type of Coverage Determination) to cover the specific drug.

To request prior authorization or an exception to cover a drug by Blue Shield Promise Heath Plan, please contact Provider Customer Service Department at (800) 468-9935, Monday through Friday, 8:30 a.m. to 5 p.m. PST, excluding holidays. Prior authorization requests can be sent electronically through the electronic health record, if available, or faxed requests may be sent to (866) 712-2731. Prescribers who have questions regarding formulary or non-formulary drugs and/or need a copy of the formulary can call the number above or go to www.blueshieldca.com/promise.

Once all required supporting information is received, a coverage decision based upon medical necessity is provided within 24 hours. The determination will be communicated to the provider in writing and by phone/fax once the final determination has been made.

10.4: Emergency Supply of Drugs Policy

Blue Shield Promise Health Plan will make every effort to ensure that members receive medications when appropriately prescribed by network providers. In most cases, the member simply obtains a prescription from his/her provider and has it filled at a participating pharmacy. However, there may be instances when approval is required for a Prior Authorization or a non-formulary drug and the pharmacy is unable to contact Blue Shield Promise Pharmacy Services in a timely manner or when the pharmacy is unable to verify eligibility after hours or on weekends. In these instances, the pharmacy will be authorized to dispense an emergency supply of drugs not to exceed a 72-hour supply.

10.5: Requirements for Hospital Emergency Rooms to Furnish Emergency Drugs

Policy

Blue Shield Promise Health Plan requires all contracted hospitals have provisions for furnishing emergency drugs for health plan members who seek treatment through the hospital's emergency room.

Procedure

1. Blue Shield Promise Health Plan's hospital contract will contain language requiring the hospital have in place emergency room policies, procedures and systems that permit the furnishing of appropriate quantities of emergency drugs to last a Member until he/she can reasonably have a prescription filled at a network participating pharmacy.
2. Any reported violations of this policy will be reviewed by the Pharmacy Department, forwarded to the Quality Management Department as a potential quality issue, will be investigated, and acted upon in accordance with established policies and procedures.

10.6: Drug Storage and Dispensing in Provider Offices

Policy

All medications, including vaccines and drug samples, used at provider sites will be stored, handled and administered according to SDHS and other state or federal regulations and according to manufacturers' recommendations.

Procedure

1. Each site shall maintain and periodically update a set of internal medication/ pharmacy policies and procedures.
2. All medications shall be stored in their original containers. This does not apply to cleaning or antiseptic solutions that may be poured into other dispensing containers.
3. Germicides, disinfectants, test reagents and household cleaning substances shall be stored separately from medications.
4. All multiple dose containers shall be labeled with the date they are originally opened.
5. All medications and related items including sample drugs shall be routinely checked for expired items.
6. All medications shall be discarded, per Title 22 requirements, when they reach their expiration date.
7. Medications shall be stored in a segregated manner according to their route of administration (i.e., oral, injectable, topical).
8. All medications, needles, and syringes are to be stored in an area only to authorized personnel.

9. Medications shall be stored at temperature levels specified by the manufacturer (i.e., room temperature, refrigerated at 35-45 degrees F or frozen at less than 7 degrees F).
10. Controlled substances (Schedule II or III) are to be stored separately from other medications in a securely locked cabinet. Controlled substances shall be inventoried, logged, and controlled. The physician is responsible for the use, storage and inventory of all controlled substances.
11. Items other than medications that are stored in a refrigerator are kept in a separate compartment from drugs.
12. Medications that are transferred from the original container into another are classified as "re- packaged". The following information is required on the new container: date of re-packaging, initials of re-packager, manufacturer name and original lot number.
13. Medications shall be prepared in a designated, clean area of sufficient size as to minimize the potential for medication errors.
14. Drugs for emergency use should be stored in a secure, locked area and a location that is accessible in an emergency.
15. A list of contents and expiration dates should be on the outside of the emergency "box".
16. The contents of the emergency "box" should match the contents list.
17. The use and/or dispensing of sample medications are discouraged. If a provider elects to use and/or dispense sample medications, the following standards must be met:
    a. A physician or pharmacist shall be responsible for the storage, inventory, and dispensing of sample medications.
    b. Only a physician or pharmacist shall dispense sample medications. This cannot be delegated to other office staff.
    c. Sample medications shall be logged when received, including the medication name, quantity, manufacturer name, lot number, and expiration date.
    d. Samples may only be dispensed to the provider's own patients.
    e. Samples may not be sold.
    f. Samples must be stored in a secure manner.
    g. If samples are dispensed, they must meet all labeling requirements.
    h. An appropriate entry is made in the patient's medical chart in a similar manner as if a prescription had been written.

10.7: Pharmaceutical Utilization Management

This program incorporates utilization management tools to encourage appropriate and cost- effective use of medications. The Blue Shield Promise Health Plan Pharmacy & Therapeutics Committee reviews and approves these requirements and limits to help us provide quality coverage to our Members. These tools include, but are not limited to: prior authorization, clinical edits, quantity limits and step therapy.

- Age limits: Some drugs may require a prior authorization if the patient's age does not meet the manufacturer, FDA, and clinical practice guidelines.
- Quantity Limits: For certain drugs, we limit the amount of the drug we will cover per prescription or for a defined period of time. Similar to the age limit, the quantity limit threshold is based on manufacturer, FDA, and clinical practice guidelines.
- Prior Authorization: Prior authorization is required for certain drugs. Typically, a prior authorization is established to ensure appropriate utilization.
- Step Therapy: In some cases, Blue Shield Promise Health Plan will require that the patient has a trial of a first-line medication, prior to approving a second-line medication.
- Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically dispense the generic version, unless the prescription indicates "brand only". If an FDA-approved generic alternative is available on the Blue Shield Promise Health Plan formulary, the prescribing physician will need to submit medical justification for the use of the brand product.
- Therapeutic interchange: Is the practice of offering clinically appropriate, cost effective formulary alternatives. Blue Shield Promise Health Plan will work with the prescribing physicians to get this accomplished.

The Blue Shield Promise Health Plan formulary is available on the Blue Shield Promise Health Plan website at www.blueshieldca.com/promise. Blue Shield Promise Health Plan Members shall have access to all FDA-approved drugs that are medically necessary via the drug formulary or prior authorization procedures. In order to ensure Members receive high quality, cost-effective and appropriate drug therapy, Blue Shield Promise Health Plan will maintain drug formularies consistent with the required pharmacy benefit design for all contracted product lines. The formularies will be maintained by the Blue Shield of California Pharmacy & Therapeutics (P&T) Committee.

10.8: Non-Legend/Over the Counter (OTC) Drug Benefit

Policy

Blue Shield Promise Health Plan will include as a health plan benefit a reasonable selection of those non-legend or OTC drugs, supplies and devices that are listed on the Medi-Cal fee-for-service formulary, or a suitable therapeutic alternative, when requested on the prescription order of a plan participating provider and obtained from a participating plan Pharmacy.

Procedure

1. When ordered pursuant to a physician's prescription, a reasonable selection of drugs, supplies and devices that can be purchased without a prescription (OTC) that are included on the Department of Health Care Services (DHCS) Medi-Cal drug formulary, or a suitable therapeutic alternative, will be provided as a plan benefit for Medi-Cal members.
2. Other OTC drugs, not included on the Medi-Cal drug formulary, may be designated as formulary drugs by the Pharmacy & Therapeutics Committee.
3. These drugs may be filled at your pharmacy. Certain drugs may need prior approval. Please check your drug formulary.

10.9: Member Charges for Pharmacy Services

Policy

Blue Shield Promise Health Plan Medi-Cal Members are not required to make a co-payment or pay a fee for service in any amount for any services included under the health plan's pharmacy services benefit.

Procedure

1. Participating pharmacy providers are required to make every attempt to verify eligibility prior to rendering or denying services. Eligibility may be verified by contacting:
    a. Blue Shield Promise Health Plan's Member Services Department or on-call nurses, if after hours
    b. The DHCS Automated Eligibility Verification System (AEVS)
    c. The L.A. Care Member Services Desk
2. If eligibility cannot be determined, the pharmacy shall dispense a minimum quantity of medication at the discretion of the pharmacist (up to a 3-day or 72 hour supply) to Members at no charge. An additional attempt to verify eligibility must be made at the earliest opportunity on the next business day. Once eligibility and benefit status have been verified, the pharmacy must contact the Member with instructions to return to the pharmacy and receive the balance of the medication order.

3. If prior authorization of a product or service is required, the pharmacy shall comply with the Blue Shield Promise Health Plan prior authorization requirements before denying plan benefit services. (Refer to Prior Authorizations and Exceptions in section 10.3)
4. It is unlawful to charge Medi-Cal Members for pharmacy prescriptions unless a request for prior authorization has been denied by the CMO. Once a denial has been determined, the informed Members may, on their own volition, pay for the medication out- of-pocket. Plan Members may appeal modifications and denials of pharmaceutical care.

10.10: Pharmacy Interpreter Service Requirement

Policy

Blue Shield Promise Health Plan will make interpreter services available to Members when accessing pharmacy services at network pharmacies during pharmacy service hours. At a minimum, telephone interpreter services will be made available, if requested, through an interpreter service for pharmacy counseling on drug dosages, drug interactions, contraindications and adverse reactions.

Procedure

1. Pharmacists and Members may access interpreter services by calling the Blue Shield Promise Health Plan toll-free Member Services number.
2. Pharmacies and Members will be notified via newsletters, handbooks, special notices, and of the availability of interpreter services.

10.11: Access to Emergency Contraception Therapy

Blue Shield Promise Health Plan will ensure appropriate Member access to emergency contraception services by requiring that its pharmacy network include competent pharmacists who have completed the proper emergency contraception training and practice in accordance with established physician-guided protocols. Pharmacy network access to emergency contraception services will be monitored through a variety of methods. The CMO is ultimately responsible for resolving all Member issues related to pharmaceutical access.

Procedure

1. Blue Shield Promise Health Plan will ensure that all pharmacists providing emergency contraception therapy are acting in accordance with the standards established in SB1169.
2. Blue Shield Promise Health Plan will ensure that authorized pharmacists are permitted to adjudicate claims electronically without requiring submission of a prescribing physician's identifier.
3. Member access issues related to pharmaceutical care or services are identified through a variety of methods, including but not limited to:
   a. Member grievances
   b. Potential quality issues (PQIs)
   c. Pharmacy credentialing and auditing
4. Access issues will be handled through the same process as other identified grievances or potential quality issues. (Please refer to the Member Services and Quality Management Departments' policies).

10.12: Access to Pharmaceutical Care and Services

Blue Shield Promise Health Plan will ensure appropriate member access to pharmaceutical care or services. If the member requires pharmaceutical care outside of Blue Shield Promise Health Plan network, the Member Services Department can direct the member to the closest network provider or pharmacy, including national pharmacy chains or mail order pharmacy for medication access.

Access to pharmaceutical care or services will be monitored through a variety of methods. The Chief Medical Officer is ultimately responsible for resolving all member issues related to pharmaceutical access.

10.13: Drug Use Review

Policy

Blue Shield Promise Health Plan will operate a drug utilization review (DUR) program focused on ensuring that outpatient drugs are appropriate, medically necessary and not likely to result in adverse medical reactions. The purpose of the DUR program is to improve the quality and cost- effectiveness of drug use. The DUR program educates physicians and pharmacists to better identify patterns, and reduce the frequency of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care, both among physicians, pharmacists, and patients, and fraud or abuse associated with specific drugs or groups of drugs.

Procedure

1. Prospective DURs are performed at the point of sale in a real time environment before the dispensing has occurred. DUR edits include, but are not limited to:
    - Drug-Age Interactions- Identifies drugs that may be used with caution or inappropriate for the submitted age of the patient.
    - Drug-Gender Interactions- Identifies drugs that may be used with caution or inappropriate for the submitted gender of the patient.
    - Drug-Drug Interactions- this interaction are coded based on severity by First Data Bank DUR module. Pharmacy is required to enter an override code for the level 1 identified interactions, most severe type of interaction.
    - Drug-Pregnancy Precautions- Identifies drugs that may be used with caution or inappropriate for women that maybe pregnant.
    - Duplication of therapy- Based on claim with the same member information, if filled on the same day or within the same therapeutic category.
    - Incorrect Dosage Alert- Based on the quantity and day supply submitted, First Data Bank DUR module with alert the pharmacy if high/low dose is identified.
    - Drug-Disease Contraindications- Based on First Data Bank's DUR module, this interaction is inferred based on current drug therapy.
    - Clinical Abuse or Misuse- Point of sale system edits that serve to limit clinical abuse or misuse within prescription drug programs. Edits include Step Therapy, Refill too soon, Prior Authorization and quantity limits programs.
    - If any of the concurrent DUR edits are identified, the dispensing pharmacy will be provided a warning message per NCPDP standards. Pharmacists are to consult with prescribing physician about the interactions.
2. Quarterly Retrospective DURs are performed. Relevant strategies to improve the quality of patient care may be created to address significant outliers, including inappropriateness or unusual prescribing trends. These proposals will be submitted to the Blue Shield Promise Health Plan Pharmacy and Therapeutics Committee for comment and approval.
3. Retrospective DURs may monitor the following:
    - Therapeutic appropriateness,
    - Over-utilization,
    - Under-utilization,
    - Appropriate generic use,
    - Inappropriate duration of treatment,
    - Incorrect drug dosage,
    - Pharmacologic duplication,
    - Drug-drug interactions, and
    - Clinical abuse and or misuse.

4. The pharmacists may perform retrospective DURs for individual members in prior authorization reviews, participation in interdisciplinary care teams, and during quarterly utilization reviews. They utilize predetermined criteria and standards to monitor for: compliance with evidence-based medication recommendations, appropriate management of medication-related complications, medically unnecessary care, possible fraud, waste, or abuse, and any overutilization/underutilization.
5. Statistical analysis of the drug utilization data by Blue Shield Promise Health Plan staff, identifies those prescribing, dispensing and drug use practices which may be out of conformance with accepted standards and or may result in medically unjustified costs.
6. Quarterly reports will be reviewed by the Blue Shield Promise Health Plan Clinical Pharmacist to identify drug use problems.
7. Record Keeping
    a. Blue Shield Promise Health Plan will comply with federal and state requirements
    b. Blue Shield Promise Health Plan will retain its files, including relevant materials review by the Health Plan to reach a decision, for a period of ten (10) years.
    c. All plan documents will be retained in hard copy or electronic and readily retrievable

10.14: Specialty Pharmaceuticals

Purpose

To establish clear policy and procedures for prescribing specialty pharmaceuticals and ensuring reliable access to these medications.

Policy

As of July 1, 2003, Blue Shield Promise Health Plan will no longer require a health care service provider to assume or be at financial risk for any item described as a qualifying self- administered specialty pharmaceutical. 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 Promise Health Plan Health Plan.

The items included in AB 2420 are:

- Injectable chemotherapeutic medications and injectable pharmaceutical therapies for side effects adjunct
- Injectable medications or blood products used for hemophilia.
- 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.

Blue Shield Promise Health Plan will establish and maintain contract(s) with a credentialed specialty pharmacy vendor(s) to ensure appropriate access to and timely delivery of specialty pharmaceuticals.

All specialty pharmaceuticals prescribed for Members associated with a non-risk medical group will require prior authorization review that may include requirements for step therapy and place of service. The Blue Shield Promise Health Plan Pharmacy Department will conduct the prior authorization review utilizing criteria and guidelines approved by the Blue Shield Promise Health Plan Pharmacy & Therapeutics Committee.

Procedure

Participating Provider Group "PPG" Not Retaining Specialty Pharmaceutical Risk and Blue Shield Promise Health Plan Directly Contracted Physicians:

1. In situations where the Member is assigned to a PPG or Blue Shield Promise Health Plan directly contracted physician where Blue Shield Promise Health Plan assumes the risk for providing specialty pharmaceuticals, physicians must obtain a prior authorization approval regardless of whether they utilize office stock, refer patient to a home infusion provider, direct the member to an outpatient facility for administration or require the services of a specialty pharmacy vendor.
2. Physicians who plan to prescribe a specialty pharmaceutical will submit a prior authorization request to the Blue Shield Promise Health Plan Pharmacy Department. Physicians may obtain a prior authorization form by calling the Blue Shield Promise Pharmacy Department.
3. The Blue Shield Promise Health Plan Pharmacy Department will review the submitted request. All determinations will be based on the Blue Shield Promise prior authorization guidelines and nationally accepted evidence-based guidelines.
4. If additional information is needed to make a final determination, the Pharmacy Department will send a request to the prescribing physician or the primary care physician. Pharmacy personnel will adhere to the HIPAA minimum necessary information requirements.
5. If the prior authorization request is approved the Blue Shield Promise Health Plan Pharmacy Department will enter a prior authorization override that permits the processing of the prescription claim by the specialty pharmacy.
6. The Blue Shield Promise Health Plan Pharmacy Department will notify the provider, Member and the specialty pharmacy in writing of the medication approval. Letters of approval will be mailed to the Blue Shield Promise Health Plan Member and a copy will be faxed to the provider. The specialty pharmacy will receive a faxed copy of the approved prior authorization form and prescription.

7. If the prior authorization request is modified or denied, the Blue Shield Promise Health Plan Pharmacy Department will notify the Member and the physician in writing.

8. All denials based on insufficient medical necessity will reference the appropriate guidelines utilized when evaluating the prior authorization request. For denials based on treatment of a condition that is not a covered benefit, the denial letter will reference the applicable state or federal regulation.

9. Upon notice of an authorized prescription, the specialty pharmacy will process the prescription in accordance with their dispensing procedures. The dispensing process will include coordination of delivery.

10. The specialty pharmacy will be responsible for verifying ongoing Member eligibility and PPG assignment for all new and refill prescriptions. If the Member is no longer eligible with Blue Shield Promise Health Plan, then subsequent authorizations and dispensing of the specialty pharmaceutical will be based on the procedures established by the newly assigned health plan.

11. In the event that the physician needs to utilize a medication stocked in his/her office, he or she will need to indicate this on the prior authorization form. If the medication and the in-office stock use are approved the physician will receive an approval notice.

12. Approval notices for specialty pharmaceuticals will include the specific medication NDC (National Drug Code). All claims should be billed utilizing the appropriate NDC code. A manual HCFA 1500 claim with NDC and HCPCS may be subsequently submitted to Blue Shield Promise Health Plan for reimbursement.

Participating Provider Group "PPG" Retaining Specialty Pharmaceutical Risk

If a Member is assigned to a PPG that has elected to keep the financial risk for specialty pharmaceuticals, Blue Shield Promise Health Plan will refer the provider and Member to the PPG for review of the prior authorization request.

10.15: Reporting

Blue Shield Promise Health Plan provides Participating Provider Groups access to pharmacy claim files. These files are available by the 10th of each month and can be accessed via a secure web portal. In order to obtain access, Participating Provider Groups are required to complete an access request form. In order to request an access request form, an email can be sent to BSCCalinxRx@blueshieldca.com. Once the access request form has been submitted and approved, access instructions and additional information will be sent to the requestor.

SECTION 11: HEALTH EDUCATION

11.1: Health Education Program

Purpose

The Health Education (HE) Program is committed to improving and maintaining the health and wellness of Blue Shield Promise Health Plan Members through health education, health promotion, skill training, interventions and disease management offered in a culturally sensitive and linguistically appropriate manner.

Goals

- Promote appropriate use of health services.
- Promote health education services.
- Encourage Member involvement with their Primary Care Physician in the management of his or her personal health.
- Increase member knowledge on preventive health care services and screenings.
- Encourage risk reduction and lifestyle changes to improve health.
- Increase use of preventive services for early detection of disease according to current guidelines for age and gender.
- Increase member's knowledge and skills to enable him or her to cope with chronic disease.
- Increase member's feelings of self-efficacy in managing chronic diseases.

11.2: Scope of Health Education (HE) Program

11.2.1: Member Education

The Blue Shield Promise Health Plan Health Education Program is committed to ensuring its member population receives quality health education services that are appropriate to their cultural and linguistic needs. The Health Education Program promotes knowledge, skills, and behavior change to increase feelings of self-efficacy so that members can manage chronic disease as well as maintain optimum health for themselves and their families. The following programs are available to Blue Shield Promise Health Plan Members through self-referral and referral from their PCP.

Members and providers may obtain more information about these programs and services by calling the HE Department.

Health Education Classes

The Health Education (HE) Department or the Utilization Management (UM) Department handles referrals for HE classes and/or other interventions. Blue Shield Promise Health Plan direct providers may refer their patients to HE services by completing and submitting the Health Education Referral Form (See Appendix 9: Health Education Referral Form) to the HE Department via fax or mail. Once the referral is received, HE will locate a health education class. If no class is available, HE will send written information to the Member on the requested topic. For referrals to programs with a cost, the provider may submit their referral using a Treatment Authorization Request (TAR) Form to the UM Department, via fax or mail. The PCP will receive documentation of the final outcome for referrals submitted the HE or UM Department. PCP's contracted through a PPG should contact the HE coordinator at the PPG to determine the referral process for health education.

Additionally, Blue Shield Promise Health Plan provides health education programs at various locations. Frequency of these classes varies depending on requests from providers and members. Most classes are implemented in English and Spanish. Some classes are implemented in Cantonese and Mandarin. Additionally, Blue Shield Promise Health Plan provides individual counseling in English, Spanish, Cantonese and Mandarin. Counseling topics include Hypertension, Hyperlipidemia, Diabetes and Weight Management. Blue Shield Promise Health Plan also implements the Stanford Healthier Living Program and the Diabetes Empowerment Education program in English, Spanish, Cantonese and Mandarin.

The Health Education Department works with the Outreach Department to coordinate activities for Blue Shield Promise Health Plan involvement in community outreach efforts and health fairs.

Health Education Materials

A variety of brochures and handouts are available to providers at no cost on the Blue Shield Promise Health Plan website at https://www.blueshieldca.com/promise/providers/index.asp?secProviders=health-education-materials

All materials selected are culturally sensitive and linguistically appropriate (refer to Section X VII Cultural and Linguistic Appropriate Services for definition s), and do not exceed the 6th grade reading level as required by the Department of Health Care Services (DHCS).

Ordering Health Education Materials

The HE Department has a variety of materials in English, Spanish, and other threshold languages available to Members and providers. Materials in languages other than English are also reviewed for cultural sensitivity and linguistic appropriateness for the target population. Materials are also available in alternative formats. Please go to Blue Shield Promise Health Plan website at https://www.blueshieldca.com/promise/providers/index.asp?secProviders=health-education-materials to download materials. If you need materials in alternative formats, call the HE department.

For providers contracted with a PPG

Please contact the health education coordinator at your affiliated PPG to order health education materials.

For providers contracted directly with Blue Shield Promise Health Plan

Please call the Blue Shield Promise Health Plan HE Department to request a materials order form.

Member Resources

The HE Department informs Members of available health education services through the Blue Shield Promise Health Plan Member newsletter, provider referrals, the Customer Service phone line, targeted mailings, Blue Shield Promise Health Plan web sites and community outreach events. The Member newsletter is mailed to each Member household and includes brief articles on a variety of health topics as well as information on Blue Shield Promise Health Plan health education programs.

Members may call the HE Department to request HE brochures or information on health education classes, and/or other interventions. Access to an over- the-phone interpreter service is also available for Members requiring interpretation.

In collaboration with L.A. Care, Blue Shield Promise Health Plan develops Preventive Health Guidelines for Adults and Children/Adolescents. These guidelines represent a compilation of recommendations from national and state organizations including the U.S. Department of Health and Human Services, National Institutes of Health, Centers for Disease Control and Prevention, U.S. Preventive Services Task Force, California Department of Public Health, and Los Angeles County Department of Public Health. Preventive Health Guidelines for Adults and Children/Adolescents are available on the Blue Shield Promise Health Plan website at https://www.blueshieldca.com/promise/members/index.asp?memSec=health-education-materials#p16.

Members may also call the Health Education Department to request a printed copy of the guidelines. Providers are notified about updates to the guidelines via provider newsletters, provider visits or blast fax. Members are notified about updates to the guidelines via member newsletters.

11.2.2: Mandated Health Education Topics

The following health related topics are those mandated by the CA DHCS:

- Age Specific Anticipatory Guidance, including information that children can be harmed by exposure to lead
- Asthma
- Breastfeeding
- Complementary and Alternative Medicine
- Diabetes
- Exercise/Physical Activity
- Family Planning
- HIV/STD Prevention
- Hypertension
- Immunizations
- Injury Prevention (intentional & unintentional)
- Nutrition
- Obesity
- Parenting
- Perinatal
- Substance Abuse
- Tobacco Prevention and Cessation
- Unintended Pregnancy

The mandated health education topics will be provided to all Members by the following methods:

- Displaying health education materials in PCP/PPG office;
- Sending health education materials to the Member's home;
- Providing health education classes;
- Providing Member newsletters;
- Providing outreach activities;
- Referring to health education community services
- Providing 24-hour nurse availability
- Providing access to a Health and Wellness portal

11.2.3: Selection of Health Education Materials

Blue Shield Promise Health Plan health education material standards represent the needs of the Blue Shield Promise Health Plan member population. All materials selected are culturally sensitive and linguistically appropriate and are at or below 6th grade reading level. A Readability and Suitability Checklist is completed for all materials. This form identifies the reviewed material's reading level, medical accuracy and cultural and linguistic appropriateness. It also includes a review of the material's content and layout. These materials and their corresponding Readability and Suitability Checklist are kept on file for review for audit purposes.

- Culturally Appropriate: Represents the member population's ethnic group, practices and behaviors based on their cultural background. Understanding of the members' cultural background is a key factor in providing quality and appropriate delivery of health education.
- Linguistically Appropriate: Represents all appropriate languages based on member population in the provider office. Selection of translation methods plays a critical role. Patient rights mandate that patients receive understandable information on illness, injuries, etc. Proper translation of English language material ensures that these rights are not violated.

Methods of Testing Reading Levels of Health Education Material

All member health education materials must be reviewed and tested using an approved tool. The Fry Readability Formula is based on the assessment of three 100-word passages from an article.

The average number of syllables and average number of sentences per 100 words are plotted on a grade level graph to determine the approximate grade level. This method will be used for most materials distributed from Blue Shield Promise Health Plan.

Health Education Material Standards

Blue Shield Promise Health Plan Health Plan is highly committed to the delivery of quality health promotion and educational materials. Before materials are purchased or created for the member population, they are carefully selected and screened. A Readability and Suitability Checklist is completed for each material. In addition to the reading level methods listed above, standards for health education materials are based on the following:

- Content/Style
- Layout/Appearance
- Visuals
- Cultural Competency
- Field Testing (if applicable)
- Medical Accuracy

11.2.4: Provider Education

The Health Education department coordinates provider education specific to Health Education. This includes providing materials on all state mandated health topics, cultural linguistic requirements, and effective techniques in patient education and communication. This is done via provider in- service education, blast faxes as well as presenting a provider health education packet during provider site visits. The provider health education packet includes information on health education and culture and linguistic requirements from DHCS, upcoming provider education programs, and how to obtain health education materials. See Section 17 for CLAS information.

The Health Education Department also educates providers on the findings from Group Needs Assessments.

Health Education information is also disseminated via provider meetings (i.e. IPA Joint Operations Committees, IPA Forums, and Medical Services Committee Meetings), provider newsletters, and special mailings.

All other operational provider information is the responsibility of the appropriate Blue Shield Promise Health Plan department. Because many provider issues overlap with health education, the Health Education Department is readily available to assist these areas in the provision of provider educational services.

11.3: Member Education Contractual Requirement

*11.3.1: **Provider's Responsibility to Health Education***

Pursuant to the contractual agreement under the Department of Health Care Services (DHCS), Member education must include the following:

- Promotion of preventive services, education and counseling.
- Promotion of appropriate use of Medi-Cal managed care plan services.
- Education of the availability of local social healthcare programs.

The provider is responsible for providing culturally sensitive and linguistically appropriate health education, prevention, and counseling services to the Member population based on their needs (See Appendix 10: Health Education State Requirements for Providers). Providers are responsible for implementing the Staying Healthy Assessment Tool. (See specifics under 11.4 of this section.) Providers are strongly encouraged to guide their patients to take increased responsibility for their personal health. The Blue Shield Promise Health Plan HE Department is responsible for providing all state mandated health education materials and associated services to Members via contracted providers. Also, 24-hour free interpretation services are available to providers with LEP patients needing interpreter services.

The provider is responsible for promoting breastfeeding to his or her patients. Research shows that breastfeeding brings many benefits to both the infant and mother. These benefits include health, nutritional, immunologic, developmental, economic and environmental.

Additionally, providers should not distribute samples or materials with formula company logos on them to their patients, as per MMCD policy letter 98-10. Providers are encouraged to refer Medi-Cal patients to WIC services.

11.3.2: PPG Provision of Health Education

The HE Department assesses the effectiveness and quality of services offered through the PPG by an annual review of the PPG's health education program. This assessment includes but is not limited to:

- Review of the HE Program description and work plan
- Review of HE Policies and Procedures
- Review of the process outlining distribution of HE materials available to providers and Members
- Process outlining HE referrals from providers to PPG
- Review of provider education on all DHCS requirements
- Submission of quarterly HE utilization reports

11.3.3: Monitoring Provisions of Health Education

The HE Department assesses the effectiveness and quality of health education services offered by providers using the following methods:

- Audits of medical records at provider sites performed by Blue Shield Promise Health Plan or L.A. Care.
- Focused review studies conducted by the Quality Management Department, assessing data obtained from various sources (i.e. medical records, encounter data, provider and Member surveys, etc.).

Medical Record Documentation of Health Education Services

Documentation of health education in medical records should include the following:

- Health education relative to the diagnosis and/or presenting problem.
- Brochures or other HE information given to the patient.
- Patient's understanding of the education provided.
- Referral to HE services (i.e., classes, counseling, program, etc.).
- Documentation of the interpreter services by the patient.
- Signature and title of all staff providing HE to patient.

11.4: Staying Healthy Assessment (SHA) Tool

All contracted Primary Care Providers must administer the SHA to Medi-Cal managed care members. The goal of the tool is to identify high-risk behaviors of individual plan members, prioritize individual health education needs related to lifestyle, environment, cultural linguistic background, and to assist providers to initiate and document focused health education interventions, referral and follow-up. Contract Medical Groups and PCPs must ensure that the SHA is administered. The tools have been updated. There are nine separate age categories. The tools have been translated into twelve non-English languages. You can access updated Staying Healthy tools at https://www.blueshieldca.com/promise/providers/index.asp?secProviders=health-education-for-providers-medi-cal. To request implementation of the SHA electronically, Providers must call the Health Education Department to request approval.

- Providers must distribute the SHA to new members within 120 days of enrollment as part of the IHA. The effective date of enrollment is the first day of the month following notification by the Medi-Cal Eligibility Data System that a member is eligible to receive benefits. Providers must distribute the SHA to current members who have not completed an updated SHA during the next preventive care office visit (e.g. well baby, well-child, well-woman exam), according to the SHA periodicity table.
- Providers must distribute the SHA to pediatric members 0-17 years of age during the first scheduled preventive care office visit upon reaching a new SHA age group. PCP's must review the SHA annually with the patient (parent/guardian or adolescent) in the intervening years before the patient reaches the next age group.
- Providers must distribute the SHA to Adolescents (12-17 years) without parental/guardian assistance beginning at 12 years of age, or at the earliest age possible to increase the likelihood of obtaining accurate responses to sensitive questions. The PCP will determine the most appropriate age, based on discussion with the parent/guardian and the families' ethnic/cultural background.
- Providers must distribute adult and senior assessments to patients 18 years and older. Although the adult assessment is intended for use by 18-55 year olds, the age at which the PCP should begin administering the senior assessment to a member should be based on the patient's health and medical status, and not exclusively on the patient's age. The adult or senior assessment must be re-administered every 3 to 5 years, at a minimum. The PCP must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re- administered.
- Annual administration of the SHA is highly recommended (not required) for the adolescent and senior groups because behavioral risk factors change frequently during these years.

- The PCP must review the completed SHA with the member and initiate a discussion with the member regarding behavioral risks the member identified in the assessment. Clinic staff members may assist a PCP in providing counseling and following up if the PCP supervises the clinical staff members and directly addresses medical issues.
- If the member refuses to complete the assessment, the refusal should be documented in the medical records.

The following will be continuous throughout the year:

- Provider training to assure appropriate implementation of the SHA.
- Distribution of the tool in English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Vietnamese, Hmong, Korean, Tagalog and Russian to all contracted PCPs (upon request or reorder). The tool will also be posted on the Blue Shield Promise Health Plan website.
- Evaluation of implementation efforts
- Monitoring will include:
  - QI chart audits
  - Encounter data

11.5: Program Resources

11.5.1: Health Education Staff

Health Education Senior Manager

The Health Education Senior Manager reports to the VP of Lifestyle Medicine. The Health Education Senior Manager works in conjunction with the Chief Medical Officer and other departments to implement health education programs appropriate to identified needs of members and providers.

The Health Education Senior Manager is responsible for developing, implementing, managing and evaluating member education programs and provider education programs related to Health Education. The Health Education Senior Manager ensures that materials and programs are culturally sensitive and linguistically appropriate to the member population under standards created by LA Care Health Plan and the DHCS.

Responsibilities of the Health Education Senior Manager include but are not limited to:

- Development, implementation and evaluation of annual Health Education Work-plan and Program.
- Development, implementation and evaluation of Policies and Procedures.
- Oversight of development, implementation, and evaluation of health education provider, member and condition specific programs.
- Oversight of evaluation and distribution of culturally and linguistically appropriate member education materials.
- Meeting the requirements of the DMHC, DHCS, and L.A. Care Health Plan and other regulatory agencies as appropriate.
- Collaborate with L.A. Care Health Plan to meet DHCS requirements.

The Health and Wellness Program Manager

The Health and Wellness Program Manager reports to the Health Education Senior Manager. The Health & Wellness Program Manager leads and manages health education initiatives and ensures compliance with NCQA, NCQA Multicultural Distinction standards, National CLAS standards, state, federal and L.A. Care requirements. Additionally, the Health & Wellness Program Manager manages the health and wellness portal.

This position collaborates with a number of external clients such as vendors, consultants, regulators and internal teams such as case managers, customer services staff, QI staff and community outreach staff.

Health Educator

The Health Educator reports to the HE Senior Manager and the Health & Wellness Program Manager and works in conjunction with them to implement health education programs appropriate to our member and provider population.

In addition, the Health Educator supports provider relations and community outreach activities, associated with member education, as well as collaborates with outside agencies.

The Health Educator assists in all aspects of program development and implementation as designated by the HE Director and Health and Wellness Program Manager. The Health Educator also assists in the development and review of member health education materials.

11.5.2: Health and Wellness Portal

The health and wellness portal is an online resource available to members. The goal of the portal is to increase members' ability to manage their health by helping them identify their risks and connecting them to self-management tools and resources that can help mitigate their risks. Members can also track their health over time on the portal. Some of the tools available on the portal include health workshops, meal plans, exercise plans, recipes, health trackers (blood pressure, cholesterol, blood glucose, nutrition) and email access to a Register Dietitian and Fitness Trainers. Members can also sign up for online or telephonic health coaching. To access the portal, members can create and account at https://blueshieldpromise.cernerwellness.com.

11.5.3: Departments in Collaboration with Health Education

Cultural and Linguistic Department

The HE Department collaborates with the Cultural and Linguistic Department to develop and implement training sessions for providers, staff and PPG's. These units also work together to ensure proper translation of health education materials into threshold languages and alternative formats. Blue Shield Promise adheres to NCQA Multicultural Distinction Standards and the National CLAS standards. The goal is to support the improvement of CLAS for our members, providers, and employees. For more information, refer to Section 17.

Quality Improvement

The Health Education Department works in conjunction with Quality Improvement (QI) to coordinate the exchange of data summarizing member needs and utilization for ongoing program planning. In addition, QI and HE work together in the implementation of various health education programs.

Customer Service Department

The Customer Service Department refers all health education related phone calls to the Health Education Department. The Customer Service Department provides 24-hour interpretation services to Blue Shield Promise Health Plan members, who speak a language other than English, through an interpreter services vendor.

Provider Relations Department

The Provider Relations Department works with the Health Education Department in identifying provider needs for health education materials and services. The Provider Relations Department also assists in the delivery of materials and information as well as in the coordination of provider education seminars.

Outreach Department

The Health Education Department works with the Outreach Department to coordinate activities for Blue Shield Promise Health Plan involvement in community outreach efforts and health fairs. Additionally, the Marketing and Community Outreach Departments work with HE to help identify health education needs of the provider.

Utilization Management

The Health Education Department works with Utilization Management to direct appropriate health education interventions for patients identified through the UM/HE referral process. Additionally, the Health Education Department assists the UM Department in educational efforts by identifying and supplying appropriate materials for UM to send to members. The HE Department supports UM Case Management by assisting with HE interventions for members referred by Case Managers.

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SECTION 12: PROVIDER SERVICES

The Provider Services Department is dedicated to educating, training, and ensuring all participating providers have a resource to voice any concern they may have.

The Provider Services staff acts as a liaison between Blue Shield Promise departments and the external provider network to promote positive communication, facilitate the exchange of information, and seek efficient resolution of provider issues. Please send your inquiries to your assigned Provider Relations Representative and keep in mind that your Provider Relations Representative is your key contact and source of information. If you are not sure who your Provider Network Representative is and/or need to contact us for any additional reason, you can reach us by email at ProviderRelations@blueshieldca.com or by phone at (800) 468-9935.

The following resources are available to you and your staff:

- Provider Relations Representative
- Provider In-Services
- Provider Manual
- Provider Bulletin
- Provider Communication
- Joint Operation Committee (Participating Provider Group "PPG" and hospitals only)

We encourage you to make recommendations and suggestions to better serve our Members and to improve the processes within our organization through open discussions and meetings.

12.1: Provider Manual Distribution

Provider Manuals are distributed to all new PPGs and hospitals during Joint Operation Committee meetings and for Blue Shield Promise direct providers within 10 Business days of placing Provider on active status. Blue Shield Promise will request and maintain documented receipt of all Provider Manuals distributed. Provider Manuals are updated annually and/or as required. Updates to our provider manual are made available online or print upon request.

12.2: Provider Orientations

Orientations are conducted by the Provider Services staff to educate new PPGs, hospitals, ancillaries and Blue Shield Promise direct contracted providers on Plan operations, policies and procedures within ten (10) business days of placing a provider on active status.

Participating Provider Groups "PPG"

Blue Shield Promise's contracted PPGs are responsible for conducting provider training and orientation for its contracted providers within ten (10) business days of placing Provider on active status with the PPG regardless of their effective status with Blue Shield Promise. PPG's are required to provide evidence of 10-day training as requested by Blue Shield Promise.

12.3: Joint Operation Committee Meetings (Participating Provider Group "PPG" & Hospitals Only)

Joint Operation Committee (JOC) meetings are conducted by the Provider Relations Representative at least annually or as needed to allow monitoring and oversight of delegated responsibilities, ensure effective problem resolution and maintain ongoing communication between Blue Shield Promise and its contracted, PPGs, and Hospitals. Blue Shield Promise will maintain documentation of attendees and issues discussed.

12.4: Provider Affiliations

Providers may become affiliated with Blue Shield Promise through a contracted PPG or Affiliations are limited to five (5) affiliations regardless of line of business.

12.5: PCP Enrollment Limits

A PCP may be assigned a maximum of 2,000 Members total. When a PCP reaches the enrollment limit the PCP's panel is closed to new enrollment until the PCP's Membership drops below the maximum level. State regulations require Blue Shield Promise to ensure the network meets the following provider to Member ratios:

Primary Care Physician	1:2,000
Mid-Level Provider	1:1,000

A PCP can limit the growth of their enrollment by requesting to close their panel. When a provider closes their panel the provider is no longer open for the auto assignment default process or Member choice selection. Exceptions may be made for existing Members.

Additionally, Blue Shield Promise has the capability of closing a provider's panel if the provider experiences access issues or has failed a facility site review. The provider's panel will re- open upon an approved corrective action plan (CAP).

12.6: Mid-Level Medical Practitioners

The use of Mid-Level Practitioners was designed to increase PCP Membership and Member access to primary care services. The number of potential assigned Members can be increased by 1,000 Members for each mid-level practitioner the PCP supervises to a maximum of 5,000 Members.

PCPs may supervise up to four (4) mid-level practitioners in any combination according to the following state regulated physician supervisor to mid-level provider ratios:

Nurse Practitioner	1:4
Physician Assistant	1:2
Midwife	1:3

The delegation of specified medical services to mid-level practitioners does not relieve the supervising physician of ultimate responsibility for the welfare of the patient or the actions of the mid-level practitioner.

12.7: Provider Network Additions (Participating Provider Group "PPG")

As a PPG, it is recommended that the necessary information for the physicians and non-physicians available through the Group be submitted to Blue Shield Promise upon notification from the listed providers below. Blue Shield Promise maintains a database of the following types of providers participating through a PPG:

- Primary Care Physicians
- Specialist Physicians
- Hospitals
- Ancillary Providers

The addition of a PPG provider requires submission of individual hardcopy documentation to the Blue Shield Provider Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.

See Section 9.14: Credentialing Program for minimum credentialing data requirements.

12.8: Provider Network Changes

The provider network changes include terminations, office relocations, leave of absences/vacation, enrollment status/restrictions and changes in PPG affiliation.

All provider changes require a minimum of 60-day advance written notification. **Providers' affiliated with Blue Shield Promise through a PPG must send notification to the PPG in accordance with their contractual agreement.** Notification of changes should be directed to the Provider Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.

12.8.1: PCP Terminations

The PPGs and/or Blue Shield Promise direct providers shall send written notification for all provider withdrawals and terminations to Provider Information & Enrollment at BSCProviderInfo@blueshieldca.com as soon as the Group is notified and at a minimum of 60 days in advance. The effective date of the change is the first of the month following the date of receipt. If a 60-day notification is not received in advance, the PCP/PPG is responsible for submitting a written coverage plan, if necessary. The Blue Shield Promise Medical Director will review the coverage plan. If the plan is denied, Blue Shield Promise will work with the PCP/PPG to determine an appropriate reassignment. Blue Shield Promise cannot guarantee that Members will remain within the PCP/PPG due to Member choice.

Blue Shield Promise retains the right to obligate the PCP/PPG to provide medical services for existing Members until the effective date of transfer. When a PPG fails to designate an appropriate provider, Members will be reassigned according to policy number 70.5.15.0.

Blue Shield Promise Directly Contracted Physicians

1. If the terminating PCP practices under a group vendor contract, the Members will remain with the group.
2. If the terminating PCP practices under a solo vendor contract, the Members will be reassigned within the Blue Shield Promise Provider Network.

Participating Provider Group "PPG"

1. If the terminating PCP practices in a FQHC, clinic or staff model, the Members will remain with the FQHC, clinic or staff model and will be transferred to an existing PCP.
2. If the terminating PCP is a solo practitioner provider and is currently affiliated with more than one PPG, the Members will be transferred to follow the PCP to another PPG that will cause least disruption to a) a hospital and/ or b) a specialist panel.
3. If the PCP is administratively terminated by Blue Shield Promise and/or PPG for reasons such as, but not limited to suspension of license, malpractice insurance, or Facility Site Review, the Members will remain within the PPG with an existing PCP at the PPG's discretion.
4. When a PPG fails to designate an appropriate provider Members will be reassigned according to Blue Shield Promise policy.

12.8.2: Office Relocation

Participating Provider Group "PPG" or Blue Shield Promise direct providers shall send 60-day prior written notification for all office relocations to the BSCProviderInfo@blueshieldca.com email. The PCP/PPG is responsible for submitting a coverage plan to Blue Shield Promise, if necessary.

PCP that changes office locations will require a facility site review (FSR). The PCP's panel will be closed to new Membership until the new location has successfully completed the FSR. Once the site is approved, the provider's address will be updated, and Members will be transferred from the existing site to the new site. If the PCP moves outside of the former office's geographic area, Blue Shield Promise will coordinate with the PPG to reassign the Members to a new PCP within Blue Shield Promise's access standard of five (5) miles but no more than ten (10) miles. In transferring Members, the provider's location, specialty and language are taken into consideration. If the PPG is unable to meet this requirement, Members will be transferred to a provider in the geographic area of the former office location.

12.8.3: Provider Leave of Absence or Vacation

PCPs/PPGs must provide adequate coverage for providers on leave of absence or on vacation. PCPs/ PPGs must submit a coverage plan to their appointed Blue Shield Promise Provider Relations Representative for any absences greater than four (4) weeks. Absences over 90 days will require transfer of Members to another Blue Shield Promise PCP.

*12.8.4: C**hange in a Provider's PPG Affiliation***

PCPs may change their Blue Shield Promise PPG affiliation by submitting written notification of the change request to the PPG that the PCP wishes to change from in accordance with the contractual agreement. A separate request is also sent to Blue Shield Promise along with a copy of the notification sent to the PPG.

Blue Shield Promise Provider Relations Representative will request validation of this information with the PPG the PCP wishes to change from in writing via Certified Mail. If no response is received from the PPG, Blue Shield Promise will process the request in accordance to the member notification policy. The terminating PPG will be notified of the effective date of the change and will be financially responsible for services until the effective date of the transfer.

Blue Shield of California
Provider Information & Enrollment
P.O. 629017
EL Dorado Hills, CA 95762-9017
Fax: (916) 350-8860
Email: BSCProviderInfo@blueshieldca.com

12.8.5: Provider Panel Status

PROVIDER/MEDICAL GROUP is required to inform the PLAN within five (5) business days when either of the following occur:

a. One or more of their providers is not accepting new patients; or,
b. One or more of their providers previously did not accept new patients and is currently accepting new patients
c. If the one or more of their providers was not accepting new patients is contacted by an enrollee/Plan Member or potential enrollee/Plan Member seeking to become a new patient, the Provider shall direct the enrollee/Plan Member or potential enrollee/Plan Member to our Member Service Department at 1-800-605-2556 (Los Angeles) or TTY 711 for assistance in selecting a new provider and to the Department of Managed Healthcare (DMHC) to report the inaccuracy by telephone at 1-888-466-2219 and/or 1-877-688-9891 (TDD) or online at www.dmhc.ca.gov.

Provider Directory Inaccuracies

Providers notify Blue Shield Promise if the provider directory information appears to be inaccurate through the following:

Providers can promptly verify or submit changes to the information listed in the directories through the following:

a. By telephone (800) 258-3091
b. Fax: (916) 350-8860
c. Email at: BSCProviderInfo@blueshieldca.com
d. Completing an online interface for providers to submit verification with requested changes generating an acknowledgment of receipt

When a report indicating that information listed in its provider directory(ies) is inaccurate, Provider Information & Enrollment will verify the reported inaccuracy and, no later than 30 business days following receipt of the report, either verify the accuracy of the information or update the information in its provider directory(ies).

When verifying a provider directory inaccuracy, Blue Shield Promise shall, at a minimum:

a. Contact the affected provider no later than 5 business days following receipt of the report; and
b. Document the receipt and outcome of each report.
c. Documentation shall include the provider's name, location, and a description of the Blue Shield Promise validation, the outcome, and any changes or updates made to its provider directory(ies).

Blue Shield Promise will terminate a provider upon confirming:

a. Provider has retired or otherwise has ceased to practice;
b. A provider or provider group is no longer under contract with the plan for any reason;
c. The contracting provider group has informed the plan that the provider is no longer associated with the provider group and is no longer under contract with the plan.

Online Profile Form

The Online Interface Form is an electronic web form that contains the required provider directory information Blue Shield Promise has on file for the provider. Providers can notify Blue Shield Promise of changes to their demographic data by completing the Online Interface Form and/or providing an affirmative response to Blue Shield Promise's Outreach Program, through the online interface.

1. Practitioners (i.e., physicians and other health professionals (i.e., PT, OT, podiatrist))
2. PPGs
3. Hospital and Ancillary providers

A system generated acknowledgment is automatically sent upon submission of an Online Profile Form.

12.8.6: Network Validation

1. Quarterly Network Validation
    a. Blue Shield Promise validates the PPGs provider network quarterly through the 274+ transaction set. The 274+ is sent to the PPG requesting they verify the network for any changes, such as provider terminations, name changes, address changes, open/closed panels etc.
2. Bi-annual Network Validation
    a. Blue Shield Promise Direct Providers receive a Provider Confirmation Data Form bi- annually containing information listed in the database. Providers are asked to validate the information and report any changes to their record(s).
3. Annual Validation
    Hospitals and Facilities are validated on an annual basis. Validation forms are sent to the contracted network requesting they verify the information in our database. Minimum data elements that are validated include:
    - Facility Name
    - Address(es)
    - City, Zip Code
    - Contact Information
    - Specialty
    - Accreditation Status

- Line of Business
- Accepting new patients
- National Provider Identifier Number (NPI)
- California License Number
- Certification Numbers

The validations include the following:

1. Provider Notice:

   a. Instructions to review and submit provider changes within 30 business days.
   b. Instructions on how the plan provider can update the information listed in the provider directory(ies) using the online interface.

2. Attestation:

   a. Receipt of network validation

   b. Confirm that the information in the provider directory or directories is current and accurate; or

   c. Update the information required to be in the directory or directories

4. Plan Provider Attestation Requirement:

Blue Shield Promise requires an attestation from plan providers, if an attestation or an update is not received from the plan provider within 30 business days, Blue Shield Promise shall:

1. Verify whether the information is correct or requires updates within 15 business days.
2. Blue Shield Promise shall document the receipt and outcome of each attempt to verify the information.
3. If Blue Shield Promise is unable to verify or update the information, a provide notification informing the provider that in 10 business days the provider will be removed from the provider directory(ies).

5. Removing a Plan Provider:

If no response to the provider notice(s) is received, after the required 10 business day notice period, the plan provider shall:

1. Be removed from the provider directory(ies) by the next required update; or If provider responds within the 10-business day notice period, plan provider will not be removed.

General acute care hospitals shall be exempt from the requirements.

12.9: Participating Provider Group "PPG" Specialty Network Oversight

As part of Blue Shield Promise pre-contractual process, a complete specialist network is required to cover the PPG's service area. Blue Shield Promise monitors the specialty network to identify and communicate any deficiencies to the PPG. The PPG is responsible for obtaining specialist contracts to correct these deficiencies within 60 calendar days, per Blue Shield Promise policy 70.5.4.4. If the PPG is unable to correct the deficiency, the PPG may make arrangements to utilize Blue Shield Promise's directly contracted specialists.

12.10: Changes in Management Service Organizations (PPG Only)

PPGs must provide a 90-day advance written notification of a change in management service organization (MSO) along with a copy of the executed contract between the PPG and the new MSO to Blue Shield Promise's Provider Services Director.

The new MSO must meet Blue Shield Promise's pre-contractual criteria. If the new MSO does not meet the criteria, the MSO is responsible for submitting a corrective action plan. Failure of the PPG/ MSO to comply will result in panel closure of all providers.

12.11: Provider Grievances

See Section 6 Grievances, Appeals, and Disputes, subsection 6.4 Provider Disputes.

12.12: Provider Directory

The Blue Shield Promise provider directory is updated each month. New enrollees receive a printed copy of the directory as part of the Medi-Cal welcome kit. Any member of the public may download a PDF copy of the directory from www.blueshieldca.com/promise. A searchable directory is also available online.

The directory lists primary care physicians, specialists, hospitals, vision providers, pharmacies, and Federally Qualified Health Clinics who see Medi-Cal patients. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their appointed contracted PPG and/or Blue Shield Provider Information & Enrollment department at BSCProviderInfo@blueshieldca.com. Providers may also review their information on the Blue Shield Promise website at www.blueshieldca.com/promise. Blue Shield Promise is committed to ensuring the integrity of the directory.

12.13: Prohibition of Billing Members

Each provider agrees that in no event including, but not limited to, nonpayment by the Plan, the Plan's insolvency or the Plan's breach of this agreement shall any Plan Member be liable for any sums owed by the Plan.

A provider or its agent, trustee, assignee, or any subcontractor rendering covered medical services to Plan Members may not bill, charge, collect a deposit or other sum; or seek compensation, remuneration or reimbursement from, or maintain any action at law or have any other recourse against, or make any surcharge upon, a Plan Member or other person acting on a Plan Member's behalf to collect sums owed by Plan.

Should Blue Shield Promise receive notice of any surcharge upon a Plan Member, the Plan shall take appropriate action including but not limited to terminating the provider agreement for cause. Blue Shield Promise will require that the provider give the Plan Member with an immediate refund of such surcharge.

SECTION 13: MARKETING - MEDI-CAL

13.1: Introduction

Marketing is critical to the success of Blue Shield Promise Health Plan and plays a vital role in:

- Creating awareness
- Building credibility to achieve enrollment growth and retention
- Educating Members about managed care

Blue Shield Promise Health Plan providers and staff are in a position to greatly influence the choices beneficiaries/patients make regarding their Medi-Cal managed health care. Providers' may encounter patients who request guidance in choosing a plan and completing an enrollment form. Providers may assist patients with the completion of the enrollment form when patients bring the form to the provider's office. HOWEVER, PROVIDERS ARE NOT ALLOWED TO HAVE BLANK, PARTIALLY COMPLETED OR COMPLETED HCO FORMS IN THEIR OFFICES FOR PATIENT SIGNATURE. NOR ARE PROVIDERS ALLOWED TO MAIL COMPLETED ENROLLMENT FORMS FOR PATIENTS. The marketing of managed care services to Medi-Cal beneficiaries is strictly regulated and monitored by Blue Shield Promise Health Plan and the California Department of Health Care Services (DHCS); therefore, Blue Shield Promise Health Plan and its providers must adhere to all regulatory guidelines.

13.2: Prohibited Conduct

Prohibited conduct includes but is not limited to:

1. False or misleading claims or representations that include, for example:
    a. A specific health plan is recommended or endorsed by any state or county agency.
    b. The state or county recommends that a Medi-Cal beneficiary enroll in a specific health plan.
    c. A Medi-Cal beneficiary will lose their Medi-Cal benefits or other welfare benefits if he/she does not enroll.
    d. Any representation that office staff is an employee(s) of the state or county.
2. The offering or giving of any form of compensation, reward or loan to induce enrollment.
3. Making use of any list of Medi-Cal beneficiary names or information obtained originally from confidential state or county data sources.
4. Providing confidential beneficiary information or data sources to health plans or other third party entities for enrollment purposes.
5. Marketing practices that discriminate against prospective Members based on race, color, marital status, religion, age, sex, national origin, ancestry, gender, gender identity, sexual orientation, disability, language or medical condition (e.g., pregnancy, disability, etc.).

6. Engaging in any Medi-Cal marketing activity on state or county premises or any other location not authorized in Blue Shield Promise Health Plan's marketing plan or by DCHS.

Blue Shield Promise Health Plan is responsible for monitoring marketing activities of its providers when such activity relates to Blue Shield Promise Health Plan and Medi-Cal. Providers must receive approval on all marketing materials containing the Blue Shield Promise Health Plan name and logo prior to use (See also Appendix 11: Notification to Providers – Marketing Restriction and Necessary Approvals).

In addition to monitoring provider marketing material development, usage and distribution, Blue Shield Promise Health Plan shall continuously and closely monitor provider outreach efforts.

Primary care physicians may NOT:

1. Coerce, threaten or intimidate patients into making a particular health plan or doctor selection.
2. Influence patients to change health plan Membership based on financial gain to the PCP.
3. Tell patients that they could lose their Medi-Cal health benefits if they do not choose a particular health plan.
4. Make any reference to competing health plans (e.g., comparing plans in a positive or negative manner) for purposes of encouraging or influencing a patient to enroll or disenroll from a particular health plan based on the PCP's financial interest.
5. Mail complete enrollment forms to HCO on behalf of patients.
6. Photocopy sample enrollment forms with the health plan and PCP names filled in for distribution to patients or to fill in the health plan and PCP names on blank enrollment forms for patients to sign and mail.
7. Use photocopied blank forms or plain-printed enrollment forms. (Only SDHS-supplied forms will be accepted).
8. Have health plan marketers stationed and enrolling in or outside the PCP office.
9. Allow PCP staff to receive any remuneration for marketing or enrolling beneficiaries.

13.3: Method for Members to Change Health Plans and Doctors

If the patient is a Member on the Commercial Plan side (i.e., Health Net, Molina,) or on regular Medi-Cal and wishes to enroll with Blue Shield Promise Health Plan (i.e., via Local Plan/L.A. Care Health Plan), he/she must complete an HCO Enrollment Form which can be mailed directly to them when they contact and request it from Blue Shield Promise Health Plan.

1. If the patient is already a local plan Member with Blue Cross, Community Health Plan or Kaiser, he/she must call L.A. Care and request a Plan Partner Transfer to Blue Shield Promise Health Plan.
2. If the patient is already a Blue Shield Promise Health Plan Member and wishes to select a different PCP, he/she must call Blue Shield Promise Health Plan and request a PCP change.

13.4: Monitoring Provider Marketing Material Development/Usage/Activity Guidelines

When using the Blue Shield Promise Health Plan name/logo:

1. Providers must submit one (1) set of materials to Blue Shield Promise Health Plan for review and approval prior to use:
    a. If materials are general in nature, and if the provider contracts with more than one health plan, only one (1) set must be submitted to a health plan.
    b. If the materials contain the names or logos of more than one health plan, the contracted provider must submit a set of materials to each health plan mentioned for review and approval.
2. Submitted materials must contain the actual tight clear legible copy. Rough ideas are unacceptable and will not be reviewed.
3. No marketing materials are to be used and/or activities done without prior
4. consent from Blue Shield Promise Health Plan. This includes general advertising used to reach Medi-Cal beneficiaries, tactical advertising with the Blue Shield Promise Health Plan name and/or logo, and collateral/promotional items such as brochures, pamphlets, pens, etc.

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SECTION 14: CLAIMS

14.1: Claim Submission

Blue Shield Promise Health Plan applies the appropriate regulatory requirements related to claims processing.

A. Blue Shield Promise Health Plan accepts claims submitted electronically or using papers. Refer to Blue Shield Promise website for updated list of electronic claims vendors. We encourage each provider to submit claims electronically as it can speed claims processing and avoid delays.

Paper claims must be submitted using the current versions of CMS-1450 (UB) and CMS 1500 forms. Paper claims and additional information such as medical records, daily summary charges and invoices must be submitted at the following address to avoid processing and payment delay:

Blue Shield Promise Health Plan
P.O. Box 4239
Montebello, CA 90640

B. Providers must ensure all claims submitted to Blue Shield Promise are complete and accurate. Complete claim means a claim or a portion there of, if separable, including attachments and supplemental information or documentation which provides "reasonably relevant information" as defined in Title 28 Section 1300.71 Claims Settlement Practices by section (a)(10), information necessary to determine payer liability as defined in section (a)(11); and:

1. For emergency services – legible emergency department reports;
2. All required/mandatory fields in current CMS-1500 form for professional services and UB-04 form for facility services adopted by the National Uniform Billing Committee (NUBC).
3. All required/mandatory fields in current CMS-1500 adopted by the National Uniform Claim Committee (NUCC).
4. Any Medi-Cal designated requirements such as Universal Product Number (UPN) for medical supplies or National Drug Codes (NDC) for pharmacy related claims.

If claims are being submitted electronically, claims must be HIPAA compliant and meet all requirements for EDI transactions. If you have electronic claim submission questions or if you would like instructions on how to submit using a clearinghouse, please email EDI_PHP@blueshieldca.com.

C. Claim Filing Limits

1. Medi-Cal claims submissions must meet the time requirements based on 22 CCR § 51008 and 51008.5.
    i. Claims must be submitted within six (6) months after the month in which the service is rendered. Claims submitted beyond six months will be subject to payment reduction.

    ii. Claims submitted beyond the six (6) months filing period, maybe paid the full allowed amount if documentations supporting the reason for delay such as:
        a. Claims submitted to the wrong payer and proof of submission such as denial letter from the wrong payer is attached.

Failure of the patient or legal representative, due to deliberate concealment or physical or mental incapacity, to present identification as a Medi-Cal beneficiary. Delayed billing shall be submitted not later than 60 days after the date certified by the provider as the date the patient was first identified as a Medi- Cal beneficiary. The date certified by the provider as the date the patient was first identified shall not be later than one year after the month in which the service was rendered.

Identification of a patient as a Medi-Cal beneficiary means presentation of any of the following for the month of service:

a. Medi-Cal card and proof of eligibility label
b. Legal proceeding has commenced in which the provider is attempting to obtain payment from a third-party payer, the provider has one year to submit the bill after the month in which the service is rendered.
c. Circumstances beyond the control of the provider.

    i. Claims submitted beyond the six months timely filing period not meeting valid delay reasons and within twelve months after month of service will be subject to a payment reduction.
    ii. Claims submitted after 12th month after month of service and not meeting valid delay reasons will be denied as untimely.

2. Payment reductions due to delay of submission:
    i. Claims received in the 7th to 9th month after month of service are subject to a payment reduction of 25%;
    ii. Claims received in the 10th to 12th month after month of service are subject to a payment reduction of 50%;
    iii. Claims received after 12th month after month of service not meeting valid delay reasons are denied as untimely.

14.2: Claims Processing Overview

A. Blue Shield Promise makes every effort to ensure claims that are Blue Shield Promise financial responsibility are paid, denied or contested within 30 calendar days of receipt. At least 90% of claims that are Blue Shield Promise financial responsibility to pay are processed within 30 calendar days of receipt or 95% within 45 working days.
   - Receipt dates are based on when Blue Shield Promise receives the claim the first time.

B. Misdirected Claims
   - Claims that are financial responsibility of the Participating Provider Group or Full Risk Hospitals are forwarded to the appropriate payer within 10 working days.
   - Billing Providers receive notices from Blue Shield Promise identifying the responsible payers.

C. Reimbursement Rates
   - To be eligible for payment, the claim must be complete and accurate.
   - Contracted providers are paid at contracted rate;
   - Non-contracted providers are paid at Medi-Cal established rates.

D. Interest payments are applied to complete claims that are not paid within 45 working days. Interest is paid for the period of the time that the payment is late.
   - Emergency services – the greater of $15 for each month period or 15% per annum; or
   - All other complete claims - 15% per annum or daily rate of 0.000411.
   - Interest payments are not made for claims where additional information is received after the original claim payment or denial, claims denied due to untimely filing and later paid because evidence of timely prior filing to the incorrect payer is submitted or claim denied due to untimely filing is paid because information about a good cause for the delay is accepted.

E. Balance Billing
   - Providers must not balance bill members for any covered/authorized services. Title 22, Section 51002 of the California Code of Regulations states "a provider of service under the Medi-Cal program shall not submit to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service."

F. Overpayment Recovery
   - Blue Shield Promise notifies provider of service in writing within three calendar year of the last claim payment when an overpayment is discovered. If the provider does not respond to the overpayment request within 41 calendar days from the first demand letter, Blue Shield Promise will begin offsetting payments of future claims equivalent to the overpayment amount.

G. Emergency Claims

- Emergency claims are paid without prior authorization. Legible emergency department reports must be submitted when billing with ER level 5. ER level 5 are forwarded and reviewed by a physician. Physician reviewer determines whether or not service meets the requirements of emergency level 5.

H. Family Planning and Sensitive Services Claims

- Claims for family planning and sensitive services (such as abortion, sexually transmitted diseases, HIV testing and counseling) do not require authorizations. Claims for sensitive services must be submitted with completed and signed DHCS Consent Form (PM 330 Form). Claims submitted without the form will be rejected and not be paid. Claims will be paid upon receipt of completed and signed PM330 form.

I. Inpatient Hospital Claims – Emergency Admission

- In the event emergency admission is not authorized prior to member's discharge, medical records must be submitted with the claims in order to determine medical necessity and avoid delay on payments. Claims with medical records are forwarded by Claims Department to Utilization Management ("UM") to determine appropriate level of care and medical necessity. Upon completion of UM's review, claims are processed and paid according to approved and authorized service.

J. Inpatient Hospital Claims – Elective Admission

- All elective inpatient admissions require prior authorization. Prior authorization, bed type and days billed versus pre-certification are verified for inpatient claims. Claims are paid according to authorized level of care. Lack of prior authorization will result in payment denials.

K. Outpatient and Other Claims

- Ambulatory services, outpatient surgeries, ancillary and specialty services, require prior authorization. Claims for these services without prior authorization will result in payment denials.

  Some services are established as no prior authorization required under the direct referral process. Please refer to the Physician Direct Referral Form for a listing of services that do not require prior authorization.

14.3: Claims Status Inquiry

Providers may verify receipt of claims within 15 days of submission to Blue Shield Promise by calling 1- 800-468-9935 ext. 3 or by checking the Blue Shield Promise Health Plan web portal at www.blueshieldca.com/promise allow the appropriate processing timeframes when obtaining claim status.

14.4: Claims Oversight and Monitoring – Participating Provider Groups

Blue Shield Promise is dedicated to ensuring that claim functions delegated to Participating Provider Groups ("PPG") are processed in accordance to regulatory requirements and contractual provisions. Blue Shield Promise monitors PPG's claims monthly claims processing timeliness and performs at the minimum annual claims audits. Blue Shield Promise audits include review of PPG's claims processing timeliness and accuracy.

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SECTION 15: ACCOUNTING

15.1: Financial Ratio Analysis (PPG Only)

The Accounting Department is responsible for the accurate financial reporting of capitation and claims expense transactions. The Managed Care Finance Department is responsible for data generation and timely payment of capitation.

PPGs must submit year-end financial statements audited by an independent certified public accountant firm within 150 calendar days after the close of the fiscal year to Blue Shield Promise and the Department of Managed Health Care (DMHC) (regulator). On a quarterly basis, financial statements must be submitted to DMHC within 45 calendar days after the quarter ends.

PPGs must estimate and document, on a quarterly basis, the organization's liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate or other actuarial firm certified methodology and calculation.

PPGs shall maintain at all times:

- A positive working capital (current assets net of related party receivables less current liability).
- A positive tangible net equity as defined in regulation 1300.76(e).
- A cash to claims ratio as defined in regulation 1300.75(f).
- A claims timeliness requirement as defined in regulation SB260.

15.2: Capitation Payment

The Capitation Department is responsible for sending the monthly capitation payments to its contracted PPGs. Capitation payments are made no later than the 10th of each month for Medi-Cal San Diego and no later than the 14th for Medi-Cal Los Angeles or within 10 days from receipt of revenue from DHCS or L.A. Care.

Capitation reports and eligibility reports are posted on a secured site or what is widely known as a Secure File Transfer Protocol ("SFTP") server. These reports are available to the PPGs no later than the 10th of each month. Each PPG is responsible for coordinating with Blue Shield of California Promise Health Plan on how to access the SFTP server. For security measures, only two individuals per PPG are issued a username and password to access this site. Any changes to the PPG's contact person will require a new password or PGP key. PPGs must request and fill out a new PGP Key Form and submit to their assigned Provider Relations Representative.

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SECTION 16: REGULATORY, COMPLIANCE AND ANTI-FRAUD

16.1: Anti-Fraud Policy and Program

State and federal agencies have increased investigations based on health care fraud and abuse laws and enforcement against providers and enrollees who violate these laws. State and federal authorities have in recent times prosecuted numerous healthcare providers for various fraudulent practices, and also mandated health care service Plans to establish anti-fraud programs.

Following this mandate and resultant industry trends, Blue Shield Promise Health Plan has developed an aggressive Compliance and Anti-Fraud Program that includes voluntary disclosure to appropriate agencies of alleged cases of fraud and abuse. Provider cooperation is essential for the success of anti-fraud and abuse efforts and as a provider of health care services to Blue Shield Promise Health Plan Members, we would like to draw your attention to this program and request your cooperation.

Health care fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. Thus, any intentional deception or misrepresentation that a provider, Member, employee, supplier or other entity makes knowing that such action could result in an unauthorized payment, benefit, denial, or other illegal action would be classified as health care fraud.

There are two ways in which providers can cooperate in Blue Shield Promise Health Plan's antifraud and abuse efforts:

1. Review practices related to services to Blue Shield Promise Health Plan Members in order to ensure that:
    a. Fee-for-service bills, if any, accurately describe the actual services performed and duplicate billing is avoided.
    b. Fee-for-service bills are not generated for capitated services.
    c. Members are not billed for covered services except for applicable co-payments.
    d. Co-payments, when applicable, are collected.
    e. Encounter data is reported accurately.
    f. Providers participate in Blue Shield Promise Health Plan utilization reviews to detect and review underutilization in a capitated environment.
    g. Blue Shield Promise Health Plan is informed about renewals and changes to all licenses and other credentials.
    h. Diagnoses and medical necessity are stated accurately, and accurate medical records are maintained.
    i. Full cooperation is demonstrated in transferring Members to Plan hospitals when medically appropriate.

j. Any marketing efforts for enrollment as Blue Shield Promise Health Plan Members are within legal limits.

2. Report any fraud and abuse or suspicious activity that may come to your attention to the Special Investigation Unit Hotline at 1-855-296-9092, anonymously. Such instances include:

   a. Any illegal or improper solicitations or offers made to you by Blue Shield Promise Health Plan employees.
   b. Any illegal or improper solicitations or offers made to you regarding services to Blue Shield Promise Health Plan Members by other providers.
   c. Any attempts by patients to use a Medi-Cal card or Blue Shield Promise Health Plan identity cards belonging to another.

If the matter relates to Medi-Cal services, providers may also call the State of California, Department of Health Services Medi-Cal Fraud Hotline at 1-800-822-6222, email to stopmedicalfraud@dhcs.ca.gov or go to http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

SECTION 17: CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

Purpose

To ensure that members receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices, and preferred language, at every medical and non-medical encounter.

Procedure

Blue Shield Promise Health Plan has adopted a CLAS Policy which is consistent with the National Standards for CLAS. Contracts between Blue Shield Promise Health Plan and PPGs, providers, hospitals and ancillary providers include a provision requiring them to participate in and comply with the performance standards, policies, procedures, and programs established from time to time by the local initiative, and Plan with respect to cultural and linguistic services including without limitation, attending training programs, and collecting and furnishing cultural and linguistic data to the local initiative, and Plan. PPG will educate and communicate cultural and linguistic requirements, policies, procedures, and programs to their contracted providers on an on-going basis.

17.1: Blue Shield Promise Health Plan and Subcontractor's Responsibility in the Provision of CLAS

Blue Shield Promise Health Plan and its subcontractors will fully comply with federal and state regulations, and DHCS, L.A. Care, and DMHC contract requirements relating to CLAS. Blue Shield Promise Health Plan does not delegate overall responsibility for culturally and linguistically appropriate services provided to plan Members, to Participating Provider Groups (PPGs) and other providers.

CLAS areas that Blue Shield Promise Health Plan will be responsible for include:

1. Hiring a cultural and linguistic specialist responsible for CLAS.
2. Developing policies and procedures on CLAS related topics and requirements and ensuring access to members' CLAS data is protected and only accessible by approved parties.
3. Sharing eligible individual member data on language needs with providers.
4. Identifying LEP members and communicating information to PPGs.
5. Providing information on language patterns of Blue Shield Promise members.
6. Sharing providers' race and/or ethnicity upon member's request.
7. Updating language capability of physicians and clinic staff in the provider directory.
8. Informing members of their rights to: Interpreting services at no cost; not use family members, including minors, or friends for interpreting; request an interpreter during discussions of medical information and explanations of plans of care; receive

translated subscriber materials in threshold languages and in alternative format (i.e., Braille, audio and large print); and file a complaint or grievance if their cultural and/or linguistic needs are not met.

9. Contracting, coordinating, and paying for 24-hour/7-day telephonic, face-to-face, and American Sign Language (ASL) interpreting services when requested by PPGs, providers and members.
10. Developing protocol on how PPGs, providers, and clinic staff can access to free interpreting services through Blue Shield Promise Health Plan.
11. Developing and distributing resources, tools, and materials to PPG (e.g., signs, language ID cards, etc.).
12. Assessing and monitoring the effectiveness of linguistic services.
13. Contracting with a qualified translation company to translate written enrollment and member informing materials in the threshold languages including: Evidence of Coverage (EOC) booklet, Provider Directory, Marketing Materials, Form Letters (denial letters, complaint and grievance materials, medical care reminders, and other legal documents). Then sharing these translated materials with the PPGs.
14. Conducting or subcontracting with qualified agencies or qualified facilitators to provide cultural competency and cultural diversity training courses for, health plan staff, PPGs, providers and clinic staff.
15. Conducting an annual analysis on the Blue Shield Promise's provider network capacity and members' needs. When gaps and/or barriers are identified, develop and implement improvement opportunities to meet member needs.
16. Working with the QI Department to address CLAS related grievances presented by members and PPGs and explore opportunities for improvement.
17. Communicating and disseminating CLAS information and requirements, and cultural competency training opportunities to PPGs and providers on an on-going basis.
18. Monitoring and overseeing CLAS programs and compliance at PPG.
19. Maintaining a committee that oversees Multicultural Distinction and CLAS oversight and approve related documentation. Blue Shield Promise members will serve as active committee members.

CLAS areas that PPGs will be responsible for include:

1. Designating a person responsible for CLAS and including responsibilities in job description. CLAS function is reflected in the organizational chart.
2. Identifying member language on monthly eligibility list sent to providers.
3. Updating Provider Directory to include language capability of providers and clinic staff.
4. Distributing signs to contracted providers on the availability of free interpreter services for LEP members and ensuring signs are posted at key points of contact.

5. Having appropriate telephone numbers and protocol to access interpreting services through the PPG or Health Plan.
6. Ensuring access to free interpreting services to LEP and hard-of-hearing or deaf members on a 24-hour/7-day basis.
7. Educating and informing providers and clinic staff on how to access interpreting services.
8. Providing and/or promoting cultural competency training to providers and clinic staff.
9. Making member-informing materials available to LEP members in the threshold languages and ensuring quality translation and cultural and linguistic appropriateness of materials. Informing providers and clinic staff what materials are available at Blue Shield Promise Health Plan and how to get them, including materials for members with disabilities (e.g., audio, Braille, large print, materials accessible online or electronic text files).
10. Having procedures for handling CLAS-related complaints made at the clinic and PPGs sites and logging grievances with CLAS-related issues.
11. Educating providers and clinic staff on the need to maintain a language capability form, certification of language proficiency or interpreting training, or similar documentation on file for bilingual staff, and staff providing interpreting services to members.
12. Educating providers and staff on the process, and availability of CLAS Community resources/ agencies. A list of resources/agencies must be kept on file and can be obtained from Blue Shield Promise Health Plan.
13. Including CLAS related questions in "Provider Satisfaction Survey" and analyzing these results to identify patterns of CLAS related problems for corrective action (optional).
14. Having written policies and procedures covering the above subjects.
15. Documenting all education of CLAS information and its dissemination to contracted providers, as well as retaining copies of agendas, sign-in sheets, handouts/materials from provider cultural competency trainings attended.

17.2: Identification of Limited English Proficient (LEP) Members

Cultural competency and linguistic capability in managed care is critically important to allow Blue Shield Promise Health Plan to meet the needs of our culturally and linguistically diverse population. Language is a medium used in every step of the health care system, from making appointments to understanding instructions and asking questions.

Definitions:

"Limited English proficient (LEP) Members" are those members that cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers and social services agencies.

"Threshold Languages" are primary languages spoken by limited English proficient (LEP) population groups meeting a numeric threshold of 3,000 or five percent (5%) of the eligible beneficiaries, whichever is lower. The Department of Health Care Services ("DHCS") designates threshold languages in each county. Languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes, are also considered threshold languages for a county.

The following ten threshold languages have been identified by DHCS for Los Angeles County: English, Spanish, Chinese (Cantonese and Mandarin), Arabic, Armenian, Cambodian/Khmer, Korean, Farsi, Filipino/ Tagalog, Vietnamese, and Russian.

For San Diego GMC, the threshold languages are Arabic, English, Spanish, Tagalog and Vietnamese. (Sources: http://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/LanguageAssistance.aspx)

"Materials in Alternative Formats" are information and materials that can be used by members with disabilities (e.g. Audio, Braille, Large Print, Materials Accessible On-line or Electronic Text File). This includes health education materials and information on how to access health plan services.

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise Health Plan and PPGs will assess their member population's language preference distributions to determine special needs and develop appropriate plans and services.
2. Blue Shield Promise Health Plan will provide a monthly new member eligibility list to PPGs and providers, which will include the primary language spoken by each member. PPGs and providers may use the eligibility list as a tool to track their LEP members.
3. Blue Shield Promise Health Plan and subcontractors will ensure members are routinely given opportunities to declare their need for culturally and linguistically appropriate services (e.g. when making an appointment, during Initial Health Assessment, on arrival, and in the exam room, etc.). Providers and clinic staff should record each member's primary language in their medical chart.

17.3: Access to Free Interpretation Services

It is the responsibility of Blue Shield Promise Health Plan and subcontractors to provide access to interpreter services, 24 hours a day, seven days a week, at no cost, to LEP and hard-of-hearing members when they access health care services.

Blue Shield Promise Health Plan and its subcontractors must not require or suggest that LEP or hard-of-hearing or deaf members provide their own interpreters or use family members or friends as interpreters. The use of such persons may compromise the reliability of medical information and could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations. **Minors should not interpret for adults.**

If, after being notified of the availability of interpreters, the member elects to have a family member or friend serve as an interpreter, providers may accept the request. However, the use of such an interpreter should not compromise the effectiveness of services nor violate the beneficiary's confidentiality.

Providers **MUST** document the request or refusal of language interpreting services by a LEP or hard- of-hearing or deaf member in the member's medical record. This will be monitored during facility site reviews and medical records review audits.

Providers and clinic staff shall follow Blue Shield Promise Health Plan protocol for requesting interpreting services to access telephonic, or face-to-face interpreting services for LEP members and American Sign Language interpreting services for hard-of-hearing or deaf members.

Providers and bilingual staff providing interpreting services **MUST** maintain an "Employee Language Skill Self-Assessment" form, certification of language proficiency or interpreting training on file.

Bilingual staff providing medical interpreting services are encouraged to take a language proficiency test by a qualified agency (e.g., Cyracom, Berlitz, Pacific Interpreters) to determine if the candidate is qualified for medical interpreting. Bilingual staff with limited bilingual capabilities or who rate "POOR" on a language proficiency test should not provide interpreting services to members and are required to use telephonic interpreting service or schedule a face-to-face interpreter for Blue Shield Promise Health Plan members. This will help avoid possible liability issues due to improper care and will be monitored during the facility site review.

17.3.1: Posting of Signs at Key Medical and Non-medical Points of Contact

Signs informing members of their right to request free interpreting services should be clearly posted at each provider office (i.e. reception area, waiting room, exam room). Blue Shield Promise Health Plan and PPGs are responsible for on-going distribution of signs/posters to the providers. To obtain signs/posters, please contact the Cultural & Linguistic Department.

17.3.2: Proficiency of Interpreters

Blue Shield Promise Health Plan and its subcontractors will ensure that limited English proficient (LEP) and hard-of- hearing or deaf members have equal access to healthcare services through the provision of high quality interpreting and linguistic services as appropriate for medical, pharmaceutical, and non-medical encounters in the member's spoken language 24 hours a day, seven (7) days per week. This includes American Sign Language (ASL) interpreting services.

Definitions:

"Medical interpreter" is a qualified bilingual staff Member, or contracted interpreter, who possesses conversational fluency in both the target language and English, and the ability to interpret medical terms (e.g., physiology, symptoms, common disease names and processes, clinical procedures, instructions and treatment plans and consent forms, etc.) in English and the target language of the LEP member.

"Non-medical interpreter" is a bilingual staff member, or contracted interpreter, with conversational fluency in both the target language and English and provides assistance to Members for administrative services (i.e., Member Orientation, scheduling appointments, non-clinical consent forms, Member Services).

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise Health Plan and its subcontractors will use the 24-hour/7-day over-the- phone interpreting service as a supplement to in-person interpretation. Subcontractors may rely on Blue Shield Promise Health Plan to access interpreting services by following the interpreting services protocol. (Please refer to Section 17.2.)
2. Documentation of linguistic competency of individuals providing interpreting services at Blue Shield Promise Health Plan or PPG must be on file. Documents may include:
    a. Written or oral assessment of bi-lingual skills.
    b. Documentation of years served as interpreter/translator.
    c. Successful completion of appropriate training programs.
    d. Confidentiality agreement or verification of confidentiality clause in contract signed by interpreter through agency.
    e. Other relevant documents signifying interpreter/translator capability (e.g., out of state certificate or license).
3. All interpreter services vendors who perform interpreting duties must sign a confidentiality agreement with Blue Shield Promise Health Plan and its subcontractors.
4. Blue Shield Promise Health Plan will retain reports of all monitoring systems for interpreting services. Monitoring can include a record of performance measures (i.e., written and/or oral testing of bilingual skills, attendance of relevant training programs and number of years interpreting, etc.); log of 24-hour telephonic interpreting services; analysis of grievances and complaint logs regarding communication or language problems; and interpreting service satisfaction questions included in the annual member and provider satisfaction survey.
5. PPG should document interpreting services utilization and maintain on file. Documentation may include a log of 24-hour telephonic interpreting services and/or number of over-the- phone and face-to-face interpreting services requests received from contracted providers.
6. Blue Shield Promise Health Plan and its PPGs may subcontract with interpreting services agencies or a language appropriate CBO to determine the qualifications of its staff and interpreters used at provider sites.

17.4: Cultural Competency Training

Blue Shield Promise Health Plan values diversity as an integral component of our organization and will promote the achievement of a cultural competent organization. Blue Shield Promise Health Plan views cultural competency as a responsibility at both the organizational and individual level.

Cultural competency training is designed to assist in the development and enhancement of interpersonal and intra-cultural skills to improve communication, access and services, and to more effectively serve our diverse membership including Seniors and People with disabilities (SPD).

Definitions:

"Culture" is a dynamic and evolving process comprised of a group's learned patterns of behavior, values, norms and practices.

"Cultural competency" is an increased working knowledge of how behaviors, values, norms, practices, attitudes and beliefs of disease, preventative practices and treatment affect medical and non-medical encounters.

"Organizational cultural competency" is the ability of an organization to adapt to diversity and actively apply knowledge of culture and linguistic issues in serving our diverse membership for improved access and health outcomes.

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise Health Plan and its subcontractors will provide and/or promote opportunities for on- going cultural competency and cultural diversity trainings to providers and staff.
2. Providers and staff are strongly encouraged to attend cultural awareness/competency training programs that are offered through L.A. Care, Blue Shield Promise Health Plan, PPGs, or other cultural awareness/competency training agencies.
3. Blue Shield Promise Health Plan and its subcontractors will retain copies, if available, of training curriculum, documentation of attendance, and schedule of training dates.
4. Blue Shield Promise Health Plan and its subcontractors will keep a list of cultural resource materials used during a training program.

17.5: Translation of Member-Informing and Health Education Materials

Written informing documents provide essential information to Members about access and usage of services. It is the responsibility of Blue Shield Promise Health Plan and the PPG to provide culturally and linguistically appropriate informing materials to Members in the threshold languages determined by the Department of Health Care Services (DHCS) and at a 6th grade reading level or below.

Member informing materials include but not limited to:

- Member Handbook
- Welcome packets
- Provider directory
- Access and availability of linguistic services
- Marketing materials
- Member surveys
- Member Newsletters
- Grievance and fair hearing process
- Form letters containing information regarding eligibility or participation criteria, and notices pertaining to reduction, denial, or termination of services or benefits.

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise Health Plan will send the Member Handbook and Welcome Packets in all threshold languages to LEP members as determined by monthly enrollment information. A tracking system will include documenting materials sent out to members in the different languages, types of materials and volume.
2. Blue Shield Promise Health Plan and its PPGs will have common letters (i.e., denials letter, informed consent, etc.) available in the language(s) that is commonly encountered based on Health Plan and PPG membership; or a system to provide members the opportunity to receive these documents in their preferred languages. Blue Shield Promise Health Plan will forward to the PPG translated member-informing materials and available health education materials.
3. A qualified translator will complete all translations. Memorandum of Understanding (MOU) contracts and information on the agencies' qualifications should be on file at health plan and PPGs.
4. Blue Shield Promise Health Plan and its PPGs will use, at the minimum, the following translation process to ensure quality translation of written Member informing materials and health education materials:

a. The document needing translation will be submitted to the "qualified translator" for translation.

Definition:
"Qualified translator" is a person with a formal education in English, with the ability to read, write and understand the target language and with knowledge of, and experience with, the culture of the intended audience.

The following three steps are done when translating a source document into the target language: (translation, editing, and proofreading). Each step is performed by a different linguist. The C&L Department will forward translated document to requesting department for final review and approval of formatting and layout of document.

17.6: CLAS Related Grievances

Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of LEP.

Therefore, a Blue Shield Promise Health Plan Medi-Cal member has the right to file a grievance if their cultural and/or linguistic needs are not met. Providers and clinic staff should know how to handle and forward CLAS related grievances presented by a patient at their office. (See Section 6: Grievances, Appeals and Disputes.) CLAS related grievances presented to Blue Shield Promise Health Plan will be handled by following these steps:

1. The Grievance Unit receives member and provider grievances and determines if the case has a CLAS related issue.
2. Blue Shield Promise Health Plan's Grievance Unit will resolve the issue with the member whenever possible.
3. If a member or provider grievance is classified or coded to have cultural and/or linguistic issues, the case will be forwarded to the Cultural and Linguistic Department.
4. The Cultural and Linguistic (C&L) specialist will investigate, follow-up, and resolve the issue with the provider and/or office staff involved with the case.
5. The Cultural and Linguistic specialist may collaborate with the Grievance Unit, Utilization Management, Quality Management, and Provider Network Operations (PNO) Departments, when necessary.
6. A copy of the actions taken will be kept on file with the Grievance Unit, PNO, and Cultural and Linguistic Departments.
7. The Cultural and Linguistic specialist will keep statistics of CLAS related grievances for trends, and statistical information will be reviewed by the CLAS manager.

17.7: Referrals to Culturally Appropriate Community Resources and Services

1. Blue Shield Promise Health Plan will distribute to providers the CLAS Community Resource Directory consisting of culturally and linguistically appropriate education and counseling services on topics such as domestic violence, counseling, cultural adaptation resource, elder care, interpreter resources, etc. during site visits, mailings, trainings, etc. Providers, clinic staff, and Members can also access the CLAS Community Directory from the Blue Shield Promise Health Plan website at www.blueshieldca.com/promise. This directory can also be obtained by contacting the CLAS Department.
2. Providers should document all referrals in the member's medical chart.
3. Blue Shield Promise Health Plan has a closed loop system in place to monitor those Members being referred to CLAS Community Services & Resource. The CLAS referral request form can be faxed to the Blue Shield Promise Health Plan CLAS Department. Once the member is referred, the provider will be informed of the member's participation to the program in an effort to encourage further follow up.
4. Providers should maintain all information provided in the member's medical record.

17.8: IPA/Medical Group Monitoring and Reporting Requirements

In order to assess the ability of a PPG to appropriately conduct CLAS, the PPG will be assessed at least annually thereafter by the Cultural and Linguistic Department. Blue Shield Promise Health Plan will also educate the providers of their direct responsibility in complying with federal regulations relating to CLAS and the provision of services to Limited English Proficient (LEP) and hard-of-hearing or deaf members.

1. The Blue Shield Promise Health Plan CLAS auditor will review, at a minimum, the following documents:
    - PPG policies and procedures on CLAS.
    - LEP identification and recording process.
    - Access to interpreting services including staff knowledge of handling interpreter needs.
    - Signs posted and other communication tools used to meet needs of LEP and hard-of- hearing or deaf members.
    - Recording requests/refusals for interpreting services in medical charts.
    - Documentation on promotion and/or attendance of CLAS Training for providers and staff.
    - Materials made available to LEP members in the threshold languages.
    - Provider satisfaction surveys conducted by the Participating Provider Group "PPG".
    - Participating Provider Group "PPG" procedures for handling CLAS related complaints made at clinic and IPA sites.

- Access to CLAS Community Resources & Agencies, the referral process for referring members to CLAS Community Agency & Resources, and how providers are informed of the need to record the referrals in the Member's medical chart.
- Documentation on dissemination/communication of CLAS related information to providers and staff.

(Some of the items above will be reviewed by Blue Shield Promise Health Plan Facility, Medical Records, QM/UM, and Health Education review staff whose reviews will be coordinated with the Cultural & Linguistic Department.)

2. The CLAS monitoring review tool will be used by the Blue Shield Promise Health Plan CLAS auditor. This monitoring tool will be provided to the PPG.
3. Blue Shield Promise Health Plan will provide guidance and educational opportunities to the IPA/PPGs for those sections that do not meet section criteria(s) within 30 days of receiving notice of the review. Blue Shield Promise Health Plan criteria for monitoring are based on Federal and State regulations and contract requirements on Culturally and Linguistically Appropriate Services (CLAS).

APPENDICES

Table of Contents

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Promise Health Plan

GRIEVANCE FORM

MEMBER INFORMATION

Member Name (Last) (First)	Birth Date: Mo. Day Yr.	Effective Date of Enrollment: Mo. Day Yr.
Address (Street) (City) (State)		(ZIP Code)
Telephone (Home)	(Work)	Number of Plan Members in Family, Including Member Grievance:
Name of person completing form, if different from member name.		(Daytime Telephone)
Where did the problem occur? (Name of Pharmacy, Hospital or Clinic)		Date of Incident: Mo. Day Yr.
Who was involved beside yourself? (Give names of involved staff, if possible.)		
Please describe what happened as specifically as possible: (Include the sequence of events and how the problem affected you.) **See Attachment**		

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against Blue Shield Promise Health Plan, you should first telephone Blue Shield Promise Health Plan at **1-800-605-2556** (TDD/TTY for the hearing impaired at **1-877-735-2929**) and use Blue Shield Promise Health Plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Blue Shield Promise Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department of Managed Health Care also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet web site, **http://www.dmhc.ca.gov)**, has complaint forms, IMR application forms, and instructions online.

ACTION REQUESTED

What would you like to see done about this problem?

See Attachment

Grievance Received By:	☐ In Person ☐ By Telephone		
Date Received: Time Received:	☐ By Mail ☐ Online	Member's Signature (optional)	Date
		I UNDERSTAND THAT THE PLAN WILL CONTACT ME WITHIN THIRTY (30) DAYS TO GIVE ME A REPORT ON ITS INVESTIGATION AND/OR ACTION REGARDING MY COMPLAINT.	

DESCRIBE WHAT HAPPENED:

ACTION REQUESTED:

(OFFICIAL USE ONLY) **OUTCOME/RESOLUTION:**
(*Complete only if an Expedited Appeal*) **Member was acknowledged verbally and notified of the 72 hours appeal process: Yes □ No □**
Grievance Received by: **Date Received:**

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FORMULARIO PARA QUEJAS

INFORMACIÓN DEL MIEMBRO

Apellido Nombre		Fecha de nacimiento: Mes Día Año	Día efectivo deinscripción: Mes Día Año
Domicilio Ciudad Estado			Zona postal
Teléfono de la casa	Teléfono del trabajo		Número de miembros inscritos incluyendo al demandante:
Nombre de la persona completando el formulario (representante), si es diferente del miembro		Télefono del representante	
¿Dónde ocurrió el problema? (Nombre de la farmacia, hospital o clínica)			Fecha del incidente: Mes Día Año
Además de usted, mencione al personal que está implicado en su queja.			

Favor de describir lo ocurrido tan especificamente sea posible (Incluya la secuencia de eventos y de que manera le afectó este problema. Use otra página si es necesario para describirlo con más detalle.)

Vea el documento adjunto

El Departamento de Atención Médica Administrada de California (DMHC, por sus siglas en inglés) se encarga de regular los planes de salud. Si usted tiene alguna queja sobre Blue Shield Promise Health Plan, debe llamar primero a Blue Shield Promise Health Plan, al **1-800-605-2556,** (para las personas con problemas auditivos, el teléfono TDD/TTY es **1-877-688-9891**) y seguir el trámite de quejas del plan, antes de comunicarse con el DMHC. El trámite de quejas no anula ningún derecho o recurso legal que usted pueda tener a su disposición. Si necesita ayuda con una queja relacionada con una emergencia, o con una queja que Blue Shield Promise Health Plan no haya resuelto satisfactoriamente, o si su queja lleva más de treinta (30) días sin ser resuelta, puede llamar a DMHC para pedir asistencia. Es posible que también pueda solicitar una Revisión Médica Independiente (IMR, por sus siglas en inglés). Si reúne los requisitos necesarios para la IMR, este proceso hará una revisión imparcial de las decisiones médicas tomadas por su plan de salud. El objetivo de la IMR es determinar la necesidad médica de un servicio o tratamiento propuesto y tomar decisiones sobre la cobertura de tratamientos de tipo experimental o de investigación y sobre disputas por el pago de servicios médicos urgentes o de emergencia. El DMHC cuenta también con un número de teléfono sin cargo **(1-888-466-2219)** y una línea TDD **(1-877-688- 9891)** para las personas con problemas auditivos o del habla. La página web del DMHC, **http:// www.dmhc.ca.gov,** incluye formularios de queja, de solicitud de IMR e instrucciones en Internet.

ACCIÓN REQUERIDA

¿Qué medida(s) quisiera que se aplicaran a este problema?

Vea el documento adjunto

Queja recibida por:	☐ En persona ☐ Por teléfono		
Fecha que se recibió: Hora que se recibió:	☐ Por correo ☐ En línea	Firma (Opcional)	Fecha
		TENGO ENTENDIDO QUE EL PLAN SE COMUNICARÁ CONMIGO DENTRO DE 30 DÍAS PARA DARME UN INFORME SOBRE SU INVESTIGACIÓN Y/O SU ACCIÓN CON RESPECTO A ESTE PROBLEMA.	

DESCRIBA LO QUE OCURRIO:

ACCIÓN REQUERIDA:

(OFFICIAL USE ONLY) **OUTCOME/RESOLUTION:**
(*Complete only if an Expedited Appeal*) **Member was acknowledged verbally and notified of the 72 hours appeal process: Yes □ No □**
Grievance Received by: **Date Received:**

Rev. 0509_Spanish

Blue Shield of California Promise Health Plan Participating Independent Physician Association / Medical Group

Delegation of Utilization Management Responsibilities

This Participating Independent Physician Association / Medical Group Delegation of Utilization Management Responsibilities Agreement ("**Agreement**") is made and entered into this **January 1, 2019** by and between **BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN,** a California corporation ("**PLAN**"), and **<<Contract Entity Name>>** ("**Medical Group**").

Medi-Cal

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
I. UM Program	☐Yes ☐No	Develop, implement and submit to Plan the UM Program outlining structure, accountability, scope, adoption of criteria, processes and other regulatory and NCQA components of UM function.	• Monitor and oversee delegated functions • Establish, publish and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** -UM Program -UM Program Evaluation -UM Workplan **Quarterly/Semi-Annual:** UM Updates (Coalition/ICE Report)	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation if CAP objectives are not achieved.

II. Outpatient specialty referrals Routine/Urgent Pre-service and retrospective review that result in an approval or denial of services	☐Yes ☐No	• Conduct review utilizing Plan approved evidence-based UM criteria and Blue Shield Promise Evidence of Coverage • Adhere to regulatory turnaround time standards for decision making • Use Plan approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) UM determinations are tracked/ monitored through UM Committee	• Monitor and oversee delegated functions • Establish, publish and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Monthly**: -Approval logs -Denial logs -Denial letters including patient clinical information **Quarterly/Semi-Annual:** UM Updates (Coalition/ ICE Report)	Pre-delegation review • Annual due-diligence audit Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation if CAP objectives are not achieved.
III. Outpatient/ ambulatory procedure referrals – Professional component Routine/Urgent Pre-service and retrospective review that result in an approval or denial of services	☐Yes ☐No	Conduct review utilizing Plan approved evidence-based UM criteria and Blue Shield Promise Evidence of Coverage Adhere to regulatory turnaround time standards for UM decision making Use Blue Shield Promise-approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) UM determinations are tracked/monitored through UM Committee Contact Plan within 24 hours for tracking number	• Monitor and oversee delegated functions • Establish, publish and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Monthly:** -Approval logs -Denial Logs -Denial letters including patient clinical information **Quarterly/Semi-Annual:** UM Updates (Coalition/ICE Report)	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation if CAP objectives are not achieved.

		for facility portion of referral **(Shared Risk only)**				
IV. A. (Shared Risk) Inpatient hospitalization, SNF, and Acute Rehab. Routine/Urgent Pre-service, retrospective and concurrent review that result in an approval or denial of services	☐ Shared responsibility ☐ Delegated responsibility ☐ N/A IPA/MG has no responsibility under this section	• Forward and coordinate all requests involving inpatient services to Plan UM Dept • Conduct review Utilizing Plan approved evidence-based UM criteria and Blue Shield Promise Evidence of Coverage • Adhere to regulatory turnaround time standards for UM decision making • Use Blue Shield Promise approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) • Continue the care until treating provider has been notified of group's decision, and care plan has been agreed upon by the treating provider • Report any acute stay over 6 days to Blue Shield Promise for coordination of care • UM determinations are tracked/monitored through UM Committee	• Conduct UM review • for inpatient services • Forward information pertaining to the concurrent review to the delegate, if available • Monitor and oversee delegated functions • Establish, publish and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	• Not applicable **Weekly** submission of authorization log (for claims processing) **Monthly** Denial Logs Denial letters including patient clinical information **Quarterly/ Semi-Annual:** UM Updates (Coalition/ ICE Report)	• Not applicable • Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Not applicable • Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation if CAP objectives are not achieved.

IV. B. (Full Risk/ Global) Inpatient Hospitalization, SNF, and Acute Rehab. Routine/Urgent Pre-service, retrospective and concurrent review that result in an approval or denial of services	☐Yes ☐No ☐ N/A IPA/MG has no responsibility under this section	• Conduct review Utilizing Plan approved evidence-based UM criteria and Plan Evidence of Coverage • Adhere to regulatory turnaround time standards for UM decision making • Use Plan approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) • Continue the care until treating provider has been notified of group's decision, and care plan has been agreed upon by the treating provider. • UM determinations are tracked/monitored through UM Committee	• Monitor and oversee delegated functions • Establish, publish and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Monthly** -Approval logs -Denial logs -Denial letters including patient clinical information **Quarterly/ Semi-Annual:** UM updates (Coalition/ ICE Report)	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation if CAP objectives are not achieved.

V. Linked Services	☐Yes ☐No	Identify the following and report number of cases to Blue Shield Promise: • CCS • DOT for TB • ESRD • Waiver Programs (home care, HIV/AIDS, etc.) • Transplants • Mental Health • Drug/Alcohol • Hospice • Custodial (Long Term Care) • EPSDT Supplemental Services • HCBS for DDS Identify the need for MLTSS services and refer to Blue Shield Promise: • CBAS • IHSS • MSSP • LTC	• Monitor and oversee delegated functions • Establish, publish and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting • Review and coordinate all MLTSS services	**Monthly Logs** **Quarterly:** <u>For LA County Only:</u> Submit to Plan using Plan approved Quarterly Supplemental Report form.	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) for elements of non-compliance Sanction per • IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of delegation if CAP objectives are not achieved within agreed timeframe.
VI. A. Complex Case Management	☐Yes ☐No	Identify and refer members for Complex Case Management Coordinate member care with the Plan	• Provide complex case management services to members meeting Plan criteria.	Not applicable	Not applicable	Not applicable

VI. B. Basic Case Management	☐Yes ☐No	Provide basic case management to members not eligible for Plan Complex Case Management and Disease Management Programs.	• Provide assistance to delegate when needed • Monitor and oversee delegated functions • Establish, publish and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Monthly Logs** **Quarterly:** For LA County Only: Submit to Plan using Plan approved Quarterly Supplemental Report form.	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) for elements of non-compliance • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation • Blue Shield Promise may conduct discretionary review to • re-measure former areas of non-compliance • Termination of delegation if CAP objectives are not achieved within agreed timeframe.

VII. Member Communica-tions	☐Yes ☐No	• Ensure member communications adhere to all regulatory standards • Obtain approval for all Member Communications from Plan prior to distribution to members	• Ongoing evaluation of Member • Communication according to regulatory standards • Provide regulatory updates to the delegate as they become available	Ongoing	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audit	
VIII. Member Appeals/ Grievances	☐Yes ☐No	• Evidence of communication stating requests for appeals are forwarded to Plan upon receipt or per Blue Shield Promise guidelines	• Review and resolve all appeals and grievances within established timeframes	Not applicable	Not applicable	Not applicable
IV. Evaluation of New Technology	☐Yes ☐No	Not applicable	• Plan evaluates the inclusion of new technology and the new application of existing technology in its benefits plan, including medical and behavioral health procedures	Not applicable	Not applicable	Not applicable

Blue Shield of California Promise Health Plan will share Member experience & Clinical Performance data with Practitioners and Providers when requested. Requests should be submitted via email to your delegation coordinator.

The Plan and Medical Group agree to accept the terms of the above.

Blue Shield of California Promise Health Plan			**<<Contract Entity Name>>**	
("Plan")			**("Medical Group")**	
By:			**By:**	
Name:			**Name:**	
Title:			**Title:**	
Date:			**Date:**	

Blue Shield of California Promise Health Plan 601
Potrero Grande Drive, Monterey Park, CA 91755 Social
Services Dept Phone: (877) 221-0208
Los Angeles Referrals Fax to: (323) 889-2109
San Diego Referrals Fax to: (619) 219-3320

SOCIAL SERVICES DEPARTMENT
REFERRAL FORM

MEMBER INFORMATION:

Member Name:_____ Member ID/CIN#: _____

Member Address:_____ City:_____ Zip Code: _____

Phone:_____ Languages Spoken: _____

Gender: Female • Male • Line of Business: Cal MediConnect • Medicare • Medi-Cal •

Referral Requested By: IPA • PCP • Specialist • Other • _____

Date of Request:_____ Requestor Name: _____

Requestor Address: _____

Requestor Phone:_____ Fax:_____

Name of person completing form:_____

Please check the box for the service(s) you would like Blue Shield of California Promise Health Plan Social Services Department to explore with the member. For more information on these programs, please call the Blue Shield of California Promise Social Services Department.

- ☐ *In-Home Supportive Services (IHSS) Members can self-refer: LA 888-944-4477 / SD 800-510-2020
- ☐ *Community Based Adult Services (CBAS)
- ☐ *Multipurpose Senior Services Program (MSSP)
- ☐ Advance Health Care Directives
- ☐ Transportation Resources
- ☐ Utility Resources
- ☐ Food Resources
- ☐ Caregiver Resources
- ☐ Legal Resources
- ☐ Housing Resources (e.g., board and care and assisted living facility referrals)
- ☐ Homeless Resources (e.g., shelter information)
- ☐ Mental Health Referrals (Contact Beacon Health Options at 855-765-9701- LA / 855-321-2211- SD)
- ☐ Other: (non-medical) For medical needs refer to UM Standard Process (TAR form). For Care Management/Populations Health Management needs, call 866-991-8222.

Reason (Indicate any attachments):

_____

*IHSS: Allows individuals to receive support services enabling them to safely remain living in their home.
*CBAS: Day health program that provides services designed to be an alternative to nursing home care for individuals over 18 years of age with special healthcare needs.
*MSSP: Provides social and health case management for seniors who are certified for nursing home placement but wish to remain at home. **THIS REFERRAL DOES NOT GUARANTEE APPROVAL OR ELIGIBILITY.**

The goal of the Social Services Department at Blue Shield of California Promise Health Plan is to assist members in eliminating the social determinants that prevent them from receiving the care they need to reach their treatment goals and safely remain living in the community setting of their choice. The Social Services Department will assess any members referred and will connect them to the appropriate community resources, including Long-Term Services and Support (LTSS) listed below.

LTSS include:

- In-Home Supportive Services (IHSS)
  - Allows individuals to receive support services enabling them to safely remain living in their home:
    - Assist with shopping
    - Preparing food
    - House keeping
    - Bathing
- Community-Based Adult Services (CBAS)
  - Day health program – provides services designed to be an alternative to nursing home care for individuals over 18 years of age with special health care needs.
    - Help people stay mentally and physically active
    - Reduce social isolation
    - Improve health
    - Prevent decline of abilities and promote self-managementin a safe, positive, and caring environment
- Multipurpose Senior Services Program (MSSP)
  - Provides social and case management for seniors who are certified for nursing home placement but wish to remain living athome.
- Long-Term Care (LTC)
  - Care provided in a skilled nursing facility for people unable to independently and safely remain living in the community. Provides 24/7 medical care.

To refer a patient to Long-Term Services and Support, please call Blue Shield of California Promise Health Plan Social Services Department at (877) 221-0208.

Request for Release of Mental Health Care Information

(Practitioner/Provider/Clinic) _____

(Address) _____ (Phone) _____

1. PATIENT INFORMATION

_____

Patient Last name, First name, Middle Initial Date of birth Former name, if any

2. REQUESTING ENTITY

(Name) _____
(Address) _____
(Phone) _____

3. REASON FOR REQUEST

I request the following mental health information regarding the above patient's outpatient treatment with a psychotherapist (as defined by Section 1010 of the California Evidence Code). Please be specific:

4. INTENDED USE OF INFORMATION

This information will be used for:

0 Further medical care 0 Payment of insurance claim 0 Other
0 Applying for insurance 0 Vocational rehab evaluation 0 Disability determination
0 Legal investigation

5. TIMEFRAME FOR USE AND DESTRUCTION

This information will be kept for:

0 30 days 0 60 days 0 90 days 0 Other – Specify

Justification for timeframes longer than 90 days _____

Prior to, or not less than three days after, the prescribed timeframe all mental health information obtained, and any copies made subsequently, will be destroyed or disposed of, caused to be destroyed or returned to the originator in a manner that preserves the confidentiality of the information contained therein.

CONFIDENTIALITY

All mental health information obtained will remain confidential and will be used solely for the purpose(s) described in #4 above and for no other purpose.

Signature of requestor_____Date _____

For Clinic Use Only:	
Date Received_____	I.D. provided_____
Date Released_____	Processed by_____

0 Sent by mail 0 Picked up in person

Notification of Extension for Use of Mental Health Care Information

(Practitioner/Provider/Clinic) _____

(Address) _____

_____

(Phone)_____

PATIENT INFORMATION:

Patient's last name _____ First name _____ M.I. ____

Date of birth / Former name, if any _____

REQUESTING ENTITY:

(Name)

_____

(Address)

_____

(Phone)

_____

INTENDED USE OF INFORMATION:

This information will be used for:

_____

_____

EXTENSION TIMEFRAME REQUESTED AND DESTRUCTION:

We request an extension for use of this information for:

0 30 days 0 60 days 0 90 days 0 Other–Specify

Reason for Extension:

_____

_____

_____

Prior to, or not less than three days after, the prescribed timeframe all mental health information obtained, and any copies made subsequently, will be destroyed or disposed of, caused to be destroyed or returned to the originator in a manner that preserves the confidentiality of the information contained therein.

CONFIDENTIALITY

All mental health information obtained will remain confidential and will be used solely for the purpose(s) described above and for no other purpose.

Signature of requestor_____

Date: _____

For Clinic Use Only:

Date Received_____ I.D. provided _____

Date Released_____ Processed by _____

0 sent by mail 0 picked up in person

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Primary Care Practitioners Access to Care Standards (PCPS)

ATTACHMENT A

Criteria	Standard
PCPs Defined as:	All practitioners providing primary care to our members which includes: General Practice, Internal Medicine, Family Practice, Pediatrics, NPs, PAs, select OB/GYNs and other specialists assigned member for primary care services.
Emergency exam	**Immediately** When a member calls the Practitioners office with an emergency medical condition they must arrange for the member to be seen immediately (preferably directing the member to the Emergency Room or calling 911) If the condition is a non-life-threatening emergency, it is still preferable for the member to be given access to care immediately but no later than six (6) hours.
Urgent PCP exam	**Within 48 hours if no authorization is required** **Within 96 hours if an authorization is required** When a member contacts the Practitioners office with an urgent medical condition we require the member to be seen within above mentioned timeframes. We strongly encourage the Practitioner to work the member in on a walk-in basis the same day. If a situation arises where a Practitioner is not available (i.e., the Practitioner is attending to an emergency or member calls late on a Friday), the member can be seen by a covering Practitioner or directed to an urgent care, covering office or emergency room.

Criteria	Standard
Sensitive Services	Sensitive services must be made available to members preferably within 24 hours but not to exceed 48 hours of appointment request. Sensitive services are services related to: • Sexual Assault • Drug or alcohol abuse for children 12 years of age or older • Pregnancy • Family Planning • Sexually Transmitted Diseases, for children 12 years of age or older • Outpatient mental health treatment and counseling, for children 12 years of • age or older who are mature enough to participate intelligently and where • either 1) there is a danger of serious physical or mental harm to the minor or others, or 2) the children are the alleged victims, of incest or child abuse. Minors under 21 years of age may receive these services without parental consent. Confidentiality will be maintained in a manner that respects the privacy and dignity of the individual.
Routine PCP, Non-urgent exam	**Within ten (10) Business Days** When a member requests an appointment for a routine, non-urgent condition (i.e., routine follow-up of blood pressure, diabetes or other condition), they must be given an appointment within 10 business days.
Initial prenatal visit to OB/GYN	**Within fourteen (14) Calendar Days** Access to OB/GYN network Practitioners is available without prior authorization.
Well child visits (For children under 2 years of age)	**Within fourteen (14) Calendar Days** When a parent of a member requests an appointment for a Well Child visit, they must be given the appointment within 14 calendar days. It is acceptable for the member to be scheduled for a covering Practitioner.
Preventive care and physical exam	**Within thirty (30) Calendar Days**
Initial Health Assessments and behavioral health screenings if not completed by the County Mental Health Plan or MBHO contracted Behavioral Health Practitioner previously.	**Within thirty (30) calendar days upon request (must be completed within 120 calendar days from when member becomes eligible)** Blue Shield Promise Health Plan encourages that this assessment is completed within the first 90 days of enrollment. Blue Shield Promise Health Plan actively sends reminders to members within this period of time encouraging them to schedule this appointment. Blue Shield Promise Health Plan requires that a Staying Healthy Assessment form is completed during this visit.

Criteria	Standard
After-hours care	Physicians are required by contract to provide **24 hours, 7 days a week coverage** to members. The same standards of access and availability are required by physicians "on-call". Blue Shield Promise Health Plan also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise Health Plan also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues.
Telephone Access	Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member's call. Urgent and emergent calls must be handled by the physician or his/her "on-call" coverage within 30 minutes. Clinical advice can only be provided by appropriately qualified staff (e.g.: physician, physician assistant, nurse practitioner or registered nurse). Blue Shield Promise Health Plan also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise Health Plan also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by hanging up and calling 911 or going to the nearest emergency room.
Waiting Time when contacting Blue Shield Promise Health Plan	During normal business hours members will not wait more than 10 minutes to speak to a plan representative.
Waiting Time in office	**Thirty (30) minutes maximum** after time of appointment
Access for Disabled Members	Blue Shield Promise Health Plan audits facilities as part of the Facility Site Review Process to ensure compliance with Title III of the Americans with Disabilities Act of 1990.
Seldom Used Specialty Services	Blue Shield Promise Health Plan will arrange for the provision of seldom used specialty services from specialists outside the network when determined medically necessary.

Criteria	Standard
Missed/ Broken Appointments (Patient fails to show for a scheduled appointment)	Missed/ Broken appointments must be documented in the medical record the day of the missed appointment and the member must be contacted by mail or phone to reschedule within 48 hours. According to the Practitioner's office's written policy and procedure provisions for a case-by-case review of members with repeated failed appointments could result in referring the member to the Health Plan for case management. Practitioners' offices are responsible for counseling such members.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Specialist Access to Care Standards

ATTACHMENT B

Criteria	Standard
SCPs Defined as:	All practitioners providing specialty care to our members, which includes all specialty types listed in Blue Shield Promise Health Plan Specialist network listing including dental, chiropractic, acupuncture and vision providers.
Emergency Care	**Immediately** When the Health Plan or Emergency Room contacts a specialty Practitioners office with an emergency medical condition they must arrange for the member to be seen immediately. If a member contacts the specialist's office with an emergency need they must contact the PCP immediately or direct the member to the Emergency Room or call 911.
Urgent Specialist Exam (no authorization required)	**Within 48 hours** When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is not required the member must be seen within 48 hours or sooner as appropriate from the time the member was referred.
Urgent Specialist Exam (authorization required)	**Within 96 hours** When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is required the member must be seen within 96 hours or sooner as appropriate from the time the referral was first authorized.
Routine specialist visit, Non-urgent exam	**Within fifteen (15) Business Days**
Routine Ancillary visit, Non-urgent exam	**Within fifteen (15) Calendar Days**
After-hours care	Physicians are required by contract to provide 24 hours, 7 days a week coverage to members. Physicians "on-call" require the same standards of access and availability. Blue Shield Promise Health Plan also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise Health Plan also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues.

Telephone Access	Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member's call. The physician or his/her "on-call" coverage must handle urgent and emergent calls within thirty (30) minutes. Appropriately qualified staff can only provide clinical advice (e.g., physician, physician assistant, nurse practitioner or registered nurse). Blue Shield Promise Health Plan also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise Health Plan also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues. Our Member Services Department will keep an abandonment rate less than 5%. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Waiting Time when contacting Blue Shield Promise Health Plan	**During normal business hours members will not wait more than 10 minutes to speak to a plan representative**
Waiting Time in office	**Thirty (30) minutes maximum after time of appointment**
Missed/Broken Appointments (Patient fails to show for a scheduled appointment)	Missed/Broken appointments must be documented in the medical record and the member's primary care Practitioner must be notified within 24 hours of the missed appointment. The member must be contacted by mail or phone to reschedule. According to the Practitioner's office's written policy and procedure provisions for a case-by-case review of members with repeated failed appointments can result in referring the member to the Health Plan for case management. Practitioners' offices are responsible for counseling such members.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Behavioral Health Access to Care Standards

ATTACHMENT C

Criteria	Standard
Life threatening/Emergency needs	**Will be seen immediately**
Non-Life-threatening emergency needs	**Will be seen within six (6) hours**
Urgent needs exam	**Within 48 hours**
Routine office visit, Non-urgent exam	**Within ten (10) Business Days**
Non-physician BH Provider: Routine office visit, Non-urgent exam	**Within ten (10) Business Days**
After-hours care	Behavioral Health services for Medi-Cal "Specialty Mental Health Services" and "Alcohol and Other Drug Programs" (AOD) are the responsibility of the appropriate County Mental Health Plan (MHP). Behavioral Health Services for Medi-Cal members with mild and moderate dysfunction outpatient services, and for all other lines of business are carved out to contracted MBHOs The MBHOs each have 24 hour a day, 7 day a week coverage. Blue Shield Promise Health Plan also has RN's on-call 24 hours a day, 7 days a week to coordinate and arrange behavioral health coverage to members.
Telephone Access	Access by telephone for screening and triage is available 24 hours a day 7 days a week, through our contracted MBHOs and the County MHPs, as appropriate. Blue Shield Promise Health Plan and its contracted MBHOs require access to a non-recorded voice within thirty (30) seconds and abandonment rate is not to exceed 5%. Blue Shield Promise Health Plan has RN's on-call at all times to arrange behavioral health coverage to members. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Standard for reaching a behavioral health professional	Blue Shield Promise Health Plan, through our contracted MBHOs, is available to arrange immediate access to a behavioral health professional. The County MHPs also have 24/7 access lines.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Ancillary Access to Care Standards

ATTACHMENT D

Criteria	Standard
Ancillary Providers	**Within fifteen (15) Business Days**, for services where prior authorization that has been obtained.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Long Term Services and Support Access to Care Standards

ATTACHMENT E

Criteria	Standard
Skilled Nursing Facility	**Within 5 Business Days of request**
Intermediate Care Facility/ Developmentally Disabled (ICF-DD)	**Within 5 Business Days of request** These services are provided by Skilled Nursing Facilities and Nursing Facilities (LTC) where 24-hour nursing services are provided.
Community Based Adult Services (CBAS)	Meeting appointment time requirements based upon the population density of counties serviced within the required wait times for appointment.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Hours of Operation Parity

ATTACHMENT F

Medi-Cal Laws require organizations to ensure that the network providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to commercial enrollees. If the Provider serves only Medi-Cal recipients, hours offered to Medi-Cal managed care enrollee must be comparable to those for Medi-Cal fee-for service members.

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: Blue Shield of CA Promise Health Plan **Plan/Medical Group Phone#: (800) 468-9935**
Plan/Medical Group Fax#: (866) 712-2731 **Non-Urgent ☐ Exigent Circumstances ☐**

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information			
First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	Male / Female	Circle unit of measure Height (in/cm):_____Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information	
Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information			
First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information			
Medication Name:			
New Therapy Renewal Step Therapy Exception Request If Renewal: Date Therapy Initiated:		Duration of Therapy (specific dates):	
How did the patient receive the medication? Paid under Insurance Name:_____ Prior Auth Number (if known):_____ Other (explain):			
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:
Administration: Oral/SL Topical Injection IV Other:			
Administration Location: Physician's Office Ambulatory Infusion Center	Patient's Home Home Care Agency Outpatient Hospital Care	Long Term Care Other (explain):_____ _____	

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification:_____ **Date**:_____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer: _____ Date/Time of Decision_____

Fax Number (_____) _____

☐ Approved ☐ Denied Comments/Information Requested: _____

blue california
Promise Health Plan

Health Education Referral Form

Complete sections A-C.

Fax to 323-889-5407

A. Patient Information

Please verify patient's current address and phone number.			
Name:			Date of referral:
DOB:	Sex: ☐ M ☐ F	Language: ☐ E ☐ S ☐ Other:	
Address:			
City:	Zip code:	Phone number:	
If patient is a minor, please provide name and language of parent/legal guardian.			
Name:		Language: ☐ E ☐ S ☐ Other:	
Diagnosis (include ICD-9 code) / Notes:			

B. Service Requested

☐ class ☐ support group ☐ one-to-one counseling* ☐ health education material

** Referrals for one-to-one nutrition counseling with a RD should be sent to patient's IPA/Medical Group.*

Topic				
	☐ Age-Specific Ant. Guidance	☐ Family Planning	☐ Lead Poisoning	☐ Obesity
	☐ Asthma	☐ HIV/STD Prevention	☐ Nutrition	☐ Tobacco Cessation
	☐ Complimentary & Alternative Medicine	☐ Hypertension	☐ Parenting	☐ Substance Abuse
	☐ Breastfeeding	☐ Immunizations	☐ Perinatal/Pregnancy	☐ Unintended Pregnancy
	☐ Dental	☐ Injury Prevention	☐ Physical Activity	☐ Other:
	☐ Diabetes			

C. Provider Information

Provider name:	
Person completing referral (if other than provider):	
Phone number:	Fax number:

Blue Shield Promise Health Plan Health Education use only	
Referral Outcome	
Provider notification date:	

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Health Education State Requirements for Providers

Please review the following Department of Health Care Services (DHCS) requirements for health education. If you need clarification on any of the requirements, please call the Health Education Department (323)827-6036 or email BlueShieldofCAHealthEducation@blueshieldca.com.

Health Education Services

Document referrals to health education services in your patient's medical record. Health education services include classes, individual counseling and support groups.

Please encourage your Blue Shield Promise Health Plan members to use our Health & Wellness portal at https://blueshieldpromise.cernerwellness.com. A few words from you can increase the likelihood that they will use the site. Members will benefit from using the site by having access to calories plans/menus, exercise guides, wellness workshops, and a health library. Additionally, members can communicate, via email, with a registered dietitian, fitness trainer and health coach.

Patient Education Materials

All health education materials you provide to your Medi-Cal patients need to be between 2nd and 6th grade reading level. Additionally, these materials need to be medically accurate, culturally sensitive and linguistically appropriate. The materials we provide you have been reviewed and meet these requirements. To order materials, please call the Health Education Department to request an order form. If you are contracted with Blue Shield Promise Health Plan through an IPA, please call your IPA Health Education Coordinator to order materials. You may also download materials from our website at https://www.blueshieldca.com/promise. Materials are available in county threshold languages and in alternative formats.

Health topics mandated by California DHCS:

• Age Specific Anticipatory Guidance	• HIV/STD Prevention	• Parenting
• Asthma	• Hypertension	• Perinatal
• Breastfeeding	• Immunization	• Physical Activity
• Complementary & Alternative Medicine	• Injury Prevention	• Substance Abuse
• Diabetes	• Nutrition	• Tobacco Prevention and Cessation
• Family Planning	• Obesity	• Unintended Pregnancy

County Threshold Languages

	English	Arabic	Armenian	Chinese	Farsi	Khmer	Korean	Russian	Spanish	Tagalog	Vietnam-ese
LA	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SD	✓	✓							✓	✓	✓

Staying Healthy Assessment

DHCS released the new Staying Healthy Assessment (SHA) via Policy Letter 13-001. Forms are available in nine age categories and various languages. All PCPs must receive training on the implementation of the SHA. To access the mandatory training, please visit https://www.blueshieldca.com/promise/providers/index.asp?secProviders=health-education-for-providers-medi-cal. There you can also download SHA forms, a provider office instruction sheet and health education materials. To request the use of an alternative Initial Health Education Behavioral Assessment (IHEBA) or to notify us of electronic implementation of the SHA, call the health education department to request the appropriate forms. Remember, a few words of advice from you can have a significant impact on changing your patients' high-risk behavior.

Breastfeeding Promotion

The American Academy of Pediatrics (AAP) supports breastfeeding as the optimal form of nutrition for infants. We encourage you to support this position by continuing to promote breastfeeding services to your patients. Also, please continue to refer your Medi-Cal patients to WIC.

Infant Formula Logos

Please do not distribute infant formula samples, educational materials or promotional materials with formula logos to Medi-Cal patients, as per MMCD Policy Letter 98-10.

Manual Breast Pumps

Breast pumps are available for breastfeeding patients. We encourage you to promote this benefit to your patients. For more information, please call the Utilization Management Department.

Tobacco Cessation Services

The All Plan Letter (APL) 16-014 supersedes MMCD Policy Letter 14-006. Providers are required to implement tobacco cessation interventions and a tobacco user identification system into their practices. Providers must:

- Conduct initial and annual assessment of each patient's tobacco use and note this information in patient's medical record.
- Offer FDA-approved tobacco cessation medications (for non-pregnant adults)
- Provide counseling using the "5 A's" model or other validated model for treating tobacco use and dependence.
- Refer patients to available individual, group and telephone counseling services
- Offer services for pregnant tobacco users.
- Provide interventions to prevent the use of tobacco in children and adolescents.

Some recommendations to identify tobacco users are:

- Add tobacco use as a vital sign in the chart or Electronic Health Records
- Use International Classification of Diseases (ICD)-10 codes in the medical record to record tobacco use.
- Place a chart stamp or sticker on the chart when the beneficiary indicates he or she uses tobacco.
- Record tobacco use in the SHA or other IHEBA.
- Record status on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM160).

To view the policy letter, learn more about the required interventions, and find training and patient resources, please visit: https://www.blueshieldca.com/promise/providers/index.asp?secProviders=tobacco_cessation.

Please contact the health education department if you would like us to schedule a tobacco cessation program specialist to come to your office to help you implement processes that will make it easier for you to identify, counsel and provide resources for your patients that smoke.

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Current Date

Dear Provider Partner:

You and your patients (Blue Shield Promise Health Plan Members) are very important to us and we are here to assist you with any questions you may have regarding marketing to Medi-Cal Members and prospects as well as any questions you may have regarding Marketing regulations.

As our partner, we have provided you with helpful information regarding the Medi-Cal program and regulatory guidelines for marketing to beneficiaries. This information can be found in Section 13 of your Blue Shield Promise Health Plan *Medi-Cal Provider Manual*. Blue Shield Promise Health Plan adheres to all marketing regulations and will continuously monitor provider activities to ensure compliance.

We encourage you to communicate with your current and prospective Medi-Cal patients about the program, health needs assessments, the services you offer and your participation with Blue Shield Promise Health Plan. When conducting such activities, please remember these important details:

Marketing is defined as, but not limited to, radio spots, bus benches, brochures, flyers, posters, newspaper ads, health fairs, etc.

Activities directed at Medi-Cal recipients and/or materials containing the word "Medi-Cal" and/or the Blue Shield Promise Health Plan name/logo must be pre-approved.

Should you have any questions, comments, concerns or wish to discuss the appropriateness of any marketing activity, please feel free to contact us OutreachActivities@blueshieldca.com.

We look forward to a long positive partnership with you and your staff,

Blue Shield Promise Health Plan
Marketing Department

Enc.

cc: Provider Manual

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Promise Health Plan

Request/Refusal Form for Interpretive Services

Patient name:

_____

Primary language:

_____

- ☐ **Yes, I am requesting interpretive services.**
  Language(s): _____
- ☐ **No, I prefer to use my family or friend as an interpreter.**
- ☐ **No, I do not require interpretive services.**
- ☐ **Not Applicable.**

Please explain: _____

_____

Patient Signature

_____

Date

Please place this form in the patient's medical record.

Request/Refusal English

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Promise Health Plan

Formulario Para Solicitar/Rechazar Servicios de Intérprete

Nombre del paciente: _____

Idioma preferido: _____

- ☐ **Si, necesito servicios de intérprete.**
  Idioma(s): _____
- ☐ **No, Prefiero utilizar un familiar o amistad como intérprete.**
- ☐ **No, requiero servicios de intérprete.**
- ☐ **No, me corresponde.**

Por favor explique: _____

_____

Firma del paciente

_____

Fecha

Please place this form in the patient's medical record.

Request/Refusal Spanish

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PROTOCOL FOR HOW TO ACCESS INTERPRETING SERVICES

(Face-to-Face, Over-the-Phone & American Sign Languages)

Why Blue Shield Promise Health Plan provides Free Interpreting Services?

"Federal Law requires that health care providers who see all government programs members provide free language assistance to limited English proficient (LEP) and hard-of-hearing or deaf persons. In order for you to meet this legal requirement, Blue Shield Promise Health Plan is providing Over-the-Phone, Face-to-Face and American Sign Language (ASL) interpreting services at no cost to Blue Shield Promise Health Plan providers and members."

When is Over-the-Phone Interpreting Services recommended?

- When you identify a patient as being limited English proficient (LEP) and the patient is already present at the office, telephone interpretation should be used immediately to avoid any delay in service.
- Telephone interpretation is available 24 HOURS A DAY, 7 DAYS A WEEK.
- When a LEP patient requests it.

DURING BUSINESS HOURS:

1. Call Blue Shield Promise Member Service Department

   Medi-Cal (All counties) **1-800-605-2556**
   Medicare & Commercial (All counties) **1-800-544-0088**
   Dual Demo (All counties) **1-855-905-3825**

OR

2. Call Pacific Interpreters

Alameda (ACCESS CODE: 845311) **1-877-904-8195**
Los Angeles (ACCESS CODE: 840609) **1-877-904-8195**
San Diego (ACCESS CODE: 838600) **1-877-904-8195**
San Francisco (ACCESS CODE: 845310) **1-877-904-8195**
San Joaquin (ACCESS CODE: 842613)**1-877-904-8195**
Santa Clara (ACCESS CODE: 841676) **1-877-904-8195**
Stanislaus (ACCESS CODE: 842615)**1-877-904-8195**
Texas (ACCESS CODE: 846273) **1-877-904-8195**

AFTER BUSINESS HOURS:

1. Call Pacific Interpreters
   All counties(ACCESSCODE:828201) **1-877-904-8195**
   - A Pacific Interpreters Customer Service Agent will ask for the following information:
   - ACCESS CODE
   - Member's First & Last Name & Blue Shield Promise ID#
   - Language Needed
   - Is this a Medi-Cal/Medicare/Dual Demo or Commercial Member?
2. If your office has After Hours Answering Services: Please ensure that their staff members can speak languages other than English; Please ensure that they know how to connect to an interpreter over the telephone.
3. If your office has On-Call Physicians/Nurses: Please ensure that they know how to connect to an interpreter over the telephone.
4. If your office has an answering machine: Please let the patients know that they need to call Pacific Interpreters.

When are Face-to-Face and American Sign Language interpreting services recommended?

- To explain complex medical consultation or education (i.e., medical diagnosis, treatment options, insulin instructions, etc.) to a LEP or a hard-of-hearing or deaf member.
- When a LEP patient requests it.

  All requests must be made with advance notice (amount of days may vary based on the company).

  Please contact Blue Shield Promise Health Plan Member Services Department for further assistance:

  Medi-Cal **1-800-605-2556**

  Medicare & Commercial **1-800-544-0088**

  Dual Demo **1-855-905-3825**

When is LifeSigns (American Sign Language) recommended?

- In case of emergency or after business hours for American Sign Language (ASL) interpreter, please call LifeSigns at **1-800-633-8883.**

Please contact Blue Shield Promise Health Plan Member Services Department at least 48 Hours in advance if the appointment has been CANCELLED or RESCHEDULED.

When is California Relay Service (TTY/Telecommunication Device for Deaf - TDD) recommended?

- When your office staff need to communicate with the hard-of-hearing or deaf patients, please call California Relay Service:

  English **1-888-877-5379**

  Spanish **1-888-877-5381**
- When your hard-of-hearing or deaf patients need assistance to call your office or Blue Shield Promise, please dial **1-800-735-2929** (Los Angeles) or **711** and **1- 866-461-4288** (San Diego).

PLEASE KEEP IN MIND

1. Always document the member's preferred language in the member's medical record.
2. Always document the request or refusal of interpreting services in the member's medical record.
3. Always post an "Interpreting Services Signs" at key medical and non-medical points of contact.
4. Please discourage patients of using friends and family members as interpreters unless the member requests it after being informed about the availability of the free interpreter services.

CULTURAL & LINGUISTICALLY APPROPRIATE SERVICES REFERRAL REQUEST FORM

Providers: Complete sections A-C and fax to the Cultural & Linguistics Department at (323) 889-5407

A. Patient Information

Member Name:		Gender	• Female • Male • Other
Member Address:			City:
Zip Code:	Phone: ( )	DOB:	Language Spoken:

B. Provider Information

Requested by:		Date of Request:
Provider Name:	Phone: ( )	Fax: ( )
Finding:		
Comments:		

C. Referral Information

Service Requested

• Social Service	• Support Group	• Community Based Organization (CBO)	• Other:

Topic

• African American	• Parenting Classes	• Cultural Transition	• Stress/Depression	• Youth/Teen
• Asian/Pacific Islander	• ESL Classes	• HIV/STD	• Interpreter Services	• Visually Impaired
• Hispanic/Latino	• Sexuality Issues	• Domestic Violence	• Employment Service	• Hard of Hearing
• Armenian/Russian	• Adoption/Foster Care	• Citizenship	• Immigration/Legal Assistance	
• Other:				

Comments:

D. Service Information

Title of Program:	Date:	Time:
Program Location:		
Address:	City:	Zip Code:
Program Contact:	Phone: ( )	

• Unable to contact Member • Member was contacted on: _____	• Will attend program • Refused program

Instructions/Comments:

E. Follow-Up

• Member attended program	• Member did not attend program	• Information not available

Comments:

C&L Department Phone#: (323) 827-6030
Fax#: (323) 889-5407

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blue california
Promise Health Plan

Provider Request to Terminate Patient/Provider Relationship

PROVIDER INFORMATION

Name (First and Last): _____

Address: _____

Phone: _____ **License #:** _____

IPA/Medical Group: _____

PATIENT INFORMATION

Name (First and Last): _____

DOB: _____ **SSN:** _____

Member ID: _____

Reasons for terminating patient/doctor relationship:

_____

_____

_____

_____

Please give specific dates and instances of the issues you have had with this member:

_____

_____

_____

What actions have you taken to resolve the issues between the member and you?

_____

_____

_____

Currently identified medical conditions requiring immediate or ongoing treatment:

_____

_____

_____

_____

It is very important to document any non-compliant behavior by the member in the member's medical records. Please provide Blue Shield Promise Health Plan with all the documentation from the member's medical records which supports your claims. You must document your actions taken to attempt to resolve these issues with the member.

Please provide the completed form and supporting documentation to the Quality Improvement Coordinator using one of the following options:

- Phone: (323) 827-6141
- Email: Quality.Review@blueshieldca.com
- Fax: (323) 323-765-2702
- Compact Disc (CD) (If submitting CD, it must be encrypted.)
- Postal Mail:
  Blue Shield Promise Health Plan
  Quality Improvement Department
  601 Potrero Grande Drive, 3rd Floor Saturn Building
  Monterey Park, CA 91755
  Attn: Elizabeth Garcia

I hereby attest that the above information is true and accurate to the best of my knowledge at this time. I also hereby attest that this request is based solely on my concern that I cannot effectively and appropriately treat the medical needs of this patient because of the above given reasons and that this request is not based on any financial motives.

Signed: _____

Date: _____