blue california
Promise Health Plan

October 16, 2020

Subject: **Notification of January 2021 Updates to the *Blue Shield Promise Health Plan Cal MediConnect Provider Manual (formerly the Blue Shield Promise Medicare Provider Manual)***

Dear Provider:

We have revised our *Blue Shield Promise Health Plan Medicare Provider Manual* and have changed the name to the *Blue Shield Promise Health Plan Cal MediConnect Provider Manual.* This manual is for providers participating in the Blue Shield Promise Cal MediConnect program. The changes listed in the following provider manual sections are effective January 1, 2021.

On that date, you can search and download the revised manual on the Blue Shield Promise Provider website at www.blueshieldca.com/promise/providers. Click on *Provider manuals* under the *policies & guidelines* heading in the middle of the page.

You may also request a CD version of the revised *Blue Shield Promise Health Plan Cal MediConnect Provider Manual* be mailed to you, once it is published, by emailing providermanuals@blueshieldca.com.

The *Blue Shield Promise Health Plan Cal MediConnect Provider Manual* is referenced in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Cal MediConnect providers contracted with Blue Shield Promise. If a conflict arises between the *Blue Shield Promise Health Plan Cal MediConnect Provider Manual* and the agreement held by the provider and Blue Shield Promise, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the January 2021 version of this manual, please contact Blue Shield Promise Provider Services at (800) 468-9935.

Sincerely,

Hugo Florez
Vice President, Provider Network Management
Promise Health Plan and PPO Specialty Networks

TBSP11237 (10/20)

UPDATES TO THE JANUARY 2021
BLUE SHIELD PROMISE HEALTH PLAN CAL MEDICONNECT MANUAL

New Pharmacy Claims Processing Vendor

Effective January 1, 2021, Blue Shield of California Promise Health Plan will have a new pharmacy claim processing vendor. CVSH will be processing pharmacy claims for all Blue Shield Promise plans. Members will receive new ID cards with updated RxBIN and RxPCN pharmacy information. Direct Member Reimbursement (DMR) forms will be updated to include CVSH information. Members who have questions about their pharmacy benefits should be directed to contact the Customer Care telephone number on their member ID cards.

Introduction

Added *introduction language about the Blue Shield Promise Cal MediConnect program:*

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) have partnered to enroll beneficiaries who are covered by both Medicare and Medi-Cal (dual eligible) into managed care health plans. This integrated care delivery program is known as the Cal MediConnect Plan (Medicare-Medicaid Plan).

Blue Shield of California Promise Health Plan is contracted with CMS and DHCS to participate in Cal MediConnect in Los Angeles and San Diego counties.

The goals of Blue Shield Promise's Cal MediConnect Plan are to improve the quality of care dually eligible managed care members receive by providing access to seamless, integrated care, and to increase the availability and access to home- and community-based services and behavioral health so members have better health outcomes and remain in their homes and communities as long as possible.

Blue Shield Promise's Cal MediConnect Plan aims to promote better care and improve alignment and coordination of Medicare and Medi-Cal benefits for dually eligible members.

Section 1: Provider Services

1.5: Provider Network Changes

Updated *timeframe to report provider changes in boldface type below:*

All provider changes require a minimum of **90** day advance written notification.

1.5.1 PCP Terminations

Updated *timeframe to report provider terminations in boldface type below and* ***added*** *language regarding PCP assignments.*

PPGs shall send written notification of all provider terminations to Provider Information & Enrollment at BSCProviderInfo@blueshieldca.com as soon as the PPG is notified and at a minimum of **90** days in advance. Blue Shield Promise Health Plan cannot guarantee that Members will remain within the PCP/PPG due to Member choice.

If the PPG/medical group wants members reassigned to specific primary care physicians, the PPG/medical group must provide that information to Blue Shield Promise at the time of the notification of PCP termination. Blue Shield Promise will strive to accommodate such requests subject to the member's right to make a final PCP selection.

1.5.5: Change in a Provider's PPG Affiliation

*This section has been **deleted and replaced** with the following language:*

PCPs may change their Blue Shield Promise Health Plan PPG affiliation by submitting written notification of their change request in accordance with their contractual agreement and with contract regulators. Blue Shield Promise Health Plan will process the request in accordance with the member notification policy. Written notification must be submitted to:

Blue Shield of California
Provider Information & Enrollment
P.O. 629017
El Dorado Hills, CA 95762-9017
Fax: (916) 350-8860 Email: BSCProviderInfo@blueshieldca.com

1.6: Provider Verification Requirements

***Added** language to align with contract language updates regarding maintaining directory data:*

In order to reduce administrative burden on providers, Blue Shield Promise delegates some provider directory maintenance tasks to a vendor. As directed by Blue Shield Promise, the provider must work with the vendor in lieu of Blue Shield Promise to complete directory maintenance tasks. This will entail executing a participation agreement with the vendor and taking other reasonably requested steps to ensure smooth exchange of directory data.

Section 2: Credentialing

2.6: Credentials Process for Participating Provider Group (PPG)

***Updated/added** Credentialing reporting requirements and timelines, as follows:*

- Delegated PPGs are required to submit a quarterly report for practitioners/ providers credentialing, recredentialing, termination and suspension activities, utilizing the Industry Collaborative Effort (ICE) standardized reporting tools found on the ICE website under *Approved ICE Documents.*
- Quarterly reports are due on the following dates:
    - 1st Quarter due May 15th (January 1st – March 30th)
    - 2nd Quarter due August 15th (April 1st – June 30th)
    - 3rd Quarter due November 15th (July 1st – September 30th)
    - 4th Quarter due February 15th (October 1st - December 31st)
- Reports may also include credentialing and recredentialing activity of Organizational Providers if oversight responsibility is delegated.
- Reports are submitted to the designated credentialing mailbox or the assigned Delegation Oversight Auditor assigned to the group.
- The PPG must develop and implement policies and procedures for ongoing monitoring of practitioner's sanctions, complaints, and quality issues between recredentialing cycles and taking appropriate action against practitioners when it identifies occurrences of poor quality. At a minimum, the Medical Group must collect and review the following:
    - Medicare and Medicaid sanctions;
    - Sanctions or limitations on licensure;

2.6: Credentials Process for Participating Provider Group (PPG) *(cont'd.)*

- Medi-Cal Suspended and Ineligible Provider List at Initial and Recredentialing;
- Medicare Opt-Out;
- Member complaints; and
- Identified adverse events.

Section 3: Member Services

3.3.1: Member Appeals

Level 1 – Health Plan Appeal

*This section has been **deleted and replaced** with the following language:*

A Cal MediConnect or Medicare Member or representative may file a standard appeal. To ask for a standard appeal, the written or verbal appeal request must be sent to Blue Shield Promise Health Plan Appeals and Grievances Dept. A fast appeal may be requested by calling, faxing, or writing to Blue Shield Promise Health Plan. If the physician provides a written or oral supporting statement explaining that the Member needs a fast appeal, then it is automatically granted to the member. If the Member or representative asks for a fast appeal without support from the physician, Blue Shield Promise Health Plan will decide if Member's health requires a fast decision. If a request for fast appeal is denied, the standard appeal will apply.

For Cal MediConnect appeals, contracted providers do not have standard appeal rights, but may request an expedited reconsideration for the member. Thus, without being a member's appointed representative, a physician is prohibited from requesting a standard reconsideration (appeal) but may expedite a member's appeal.

For Part D appeals, a prescribing physician or other prescriber acting on behalf of the member or staff of a physician's office action on a physician's behalf may request an expedited redetermination without being the member's appointed representative.

Level 2 – Independent Review Entity (IRE)

***Added** language in boldface type below:*

Appeals should be filed within sixty (60) calendar days from the date of the initial determination, **unless the IRE extends the timeframe for good cause.**

***Added** the following section for Medi-Cal appeals:*

Medi-Cal Level 2 Appeals:

Independent Medical Review (IMR)

Members can request an Independent Medical Review within 6 months after a decision has been made by Blue Shield Promise Health. IMR requests are made to the Department of Managed Health Care. IMRs are free to the member.

State Hearing

The State Hearing request is for Medi-Cal covered services. A member can request a State Hearing within 120 days after the member receives the "Your Rights" notice during the Public Health Emergency created by COVID-19. After the public health emergency ends, a member can request a State Hearing within 90 days after the member receives the "Your Rights" notice.

3.3.2: Member Grievances

Deleted *the Member Services telephone number and* ***replaced*** *it with (855) 905-3825.*

Added *language indicating that* Grievances can be filed online at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/cmc-members/cmc-members under *Get to Know Blue Shield Promise Cal MediConnect*, then *Submit a grievance form online.*

3.3.3: Provider Disputes

Renamed *to 3.3.3 Provider Appeals.*

3.3.3.1: Provider Questions, Concerns and Disputes

Renamed *to 3.3.3.1 Provider Questions, Concerns and Appeals.*

3.3.3.3: Provider Disputes Policy and Procedure

Contracted and Non-Contracted Providers

This section has been ***deleted and replaced*** *with the following language:*

Providers may submit a written appeal to the Blue Shield Promise Health Plan Provider Dispute Department. Appeals may pertain to such issues such as post service authorization or denial of a service; nonpayment or underpayment of a claim; or disputes with our delegated entities.

All written, formal appeals will be responded to in writing. Upon receipt of the written appeal specifying the issue of concern, the appeal will be entered into the provider dispute database.

All provider appeals must be submitted in writing. If a provider attempts to file a provider appeal 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 an appeal can be found on the Blue Shield Promise Health Plan website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms/disputes-medi-cal.

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

3.3.3.4: First Level Appeal

Updated *language to indicate that the Provider Dispute Department will send a written letter of resolution to the provider within* ***60*** *calendar days of receipt of appeal for contracted and non-contracted provider disputes.*

Section 4: Eligibility and Enrollment

4.5: Disenrollment

Clarified *that individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program and are enrolled in a Cal MediConnect plan, CMS allows individuals to enroll in, or disenroll from, a Cal MediConnect plan or an MA plan, on a continuous basis.*

Section 5: Utilization Management

5.4: Direct Access to Women's Health Services

***Added** the following language to comply with AB 2193 regulations:*

As of July 2019, California law (AB 2193) requires that licensed health care practitioners providing prenatal or postpartum care for a patient must ensure the patient is offered a screening, or is appropriately screened, for any type of mental health conditions that may be occurring. In accordance with the law, Blue Shield Promise Health Plan requires all participating network practitioners, as well as delegated entities that contract with individual practitioners, to comply with the requirement included in Article 6, Section 123640 (September 2018) of California's Health and Safety Code, following approval of the Assembly Bill 2193 (AB 2193) approved in September 2018.

Blue Shield Promise Health Plan has developed a Maternal Mental Health Program to assist participating practitioners and delegated entities in implementing the requirement. Providers may visit Blue Shield Promise Health Plan's Behavioral Health Services Program webpage at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/behavioral-health-services to view information on required frequency of maternal mental health screenings, approved screening tools, and the appropriate codes to submit with encounters data once the screening has occurred.

Section 6: Pharmaceutical Management

6.1: Medication Therapy Management (MTM) Program

*This section has been **deleted and replaced** with the following language:*

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

- Have two of the following conditions:
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Dyslipidemia
  - Hypertension
  - Osteoporosis
  - Respiratory Disease
- Receive seven or more different covered Part D maintenance medications monthly
- Likely to incur an annual cost threshold established by CMS each calendar year for Medicare covered prescriptions

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

Members have the option to speak with a designated pharmacist to discuss their medication therapy issues. The pharmacist consultations are designed to improve member health while controlling out-of-pocket costs and may include topics such as:

- Drug adverse reactions
- Drug side-effects
- Drug-drug interactions
- Drug-disease interactions
- Medication non-compliance and non-adherence
- Duplicate therapy
- Dosing that can be consolidated
- Non-prescription drug use

A written summary of the consultation with relevant assessments and recommendations will be provided to the member. The member's prescribing physician or primary care physician may be contacted by the pharmacist to coordinate care or recommend therapy changes when necessary.

6.3.1: Prior Authorizations and Exceptions

Added *language on ways to submit prior authorizations requests:*

Prior authorization requests can be submitted electronically by utilizing an electronic prior authorization vendor such as Surescripts or Cover My Meds. Prior authorization requests can also be faxed to (888) 697-8122.

6.4 Member Coverage, Determination, Exceptions, and Appeals

Deleted *the entire section as Section 6.3 already covers this topic.*

Section 7: Quality Improvement

7.1: Quality Improvement Program

Updated *language to align with our current quality program documents, including but not limited to the mission, goals, objectives, structure, committees, and QI process.*

7.4: Practitioner/Provider and Member Satisfaction Surveys

Renamed *to 7.4 Clinician and Member Satisfaction Surveys.*

Clinician Satisfaction Survey

This section has been ***deleted and replaced*** *with the following language:*

Blue Shield Promise established and implemented one annual uniform satisfaction survey for clinician practices. The Clinician Satisfaction Survey gauges satisfaction rates to guide Blue Shield Promise's process enhancements geared toward improved access, care delivery and quality that demonstrate year-over-year improvement in the majority of measured categories. Blue Shield Promise conducts the annual Clinician Satisfaction Survey with participating primary and specialty care clinicians using an NCQA-certified/CMS-approved consultant. Results of the Clinician Satisfaction Survey are summarized and reported to the appropriate departments and committees for follow-up and action.

7.6: Access to Care Standards

Procedure

Added *the following new language:*

Blue Shield Promise provides and arranges for the provision of covered health care services in a timely manner appropriate for the nature of each member's condition consistent with good professional practice. Blue Shield Promise establishes and maintains provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with clinical appropriateness standards.

Plan-to-Plan Arrangements

In addition to measuring compliance with clinical appropriateness standards for each member's condition relative to good professional practice, Blue Shield also ensures compliance with the network components offered under plan-to-plan arrangements. Plan-to-Plan arrangements include all or some behavioral health, dental, vision, chiropractic, and acupuncture provider services. Blue Shield Promise ensures that services covered under a plan-to-plan arrangement provide an adequate network for existing and potential member capacity as well as adequate availability of providers offering members appointments for covered services in accordance with the requirements.

7.7.1: Broken/Failed Appointment Follow-up

Policy

Added *language in boldface type below:*

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, **within 48 hours**, who fail to keep scheduled appointments. **Outreach to patients is documented within the medical records.**

Section 8: Encounter Data

Reorganized *section to match procedures across different lines of business. No material changes to the content.*

Section 9: Claims

9.1. Claims Submission

C. Claims Filing Limits has been ***deleted and replaced*** *with the following language:*

C. Claim Filing Limits

Contracted providers must submit clean claims to Blue Shield Promise Health Plan within the timeframe specified in your contract with Blue Shield Promise. Providers which are not contracted with Blue Shield Promise must submit Medi-Cal claims no later than 12 months from the date of service (42 CFR 447.45). Providers which are not contracted with Blue Shield Promise must submit Medicare claims no later than one calendar year from the date of service (42 CFR 424.44).

9.4 Claims Oversight and Monitoring – Participating Provider Groups

Renamed *to 9.4 Claims Compliance and Monitoring. This section has been* ***deleted and replaced*** *with the following language:*

Definitions:

"*Delegated Entity*" describes any party who enters into a legal agreement by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.

Blue Shield Promise Health Plan is dedicated to ensuring that claim functions assigned to Delegated Entities are processed in accordance with regulatory requirements and contractual provisions.

Blue Shield Promise monitors Delegated Entities' monthly and quarterly claims processing timeliness via the Delegated Entity's submission of the monthly/quarterly timeliness report. Additionally, Blue Shield Promise monitors the Delegated Entity's provider dispute resolution (PDR) process via submission of the quarterly Cal MediConnect Report. Both report templates are available from Delegation Oversight Claims Team or located on the Industry Collaborative Effort (ICE) website under *Approved ICE Documents.*

Blue Shield Promise performs, at a minimum, annual claims and PDR audits. Follow-up/focused audits will be scheduled by the assigned auditor if the Delegated Entity fails the annual audit. If applicable, as a result of a non-compliant follow-up audit, additional monitoring and/or audits will be performed. Additionally, Blue Shield Promise may perform an unannounced audit dependent upon other indicators.

9.4 Claims Compliance and Monitoring *(cont'd.)*

Blue Shield Promise audits include review of Delegated Entity's claims and PDR processing according to regulatory and contractual requirements, including but not limited to section 42 CFR 447.45 as noted in the Cal MediConnect Program three- way Contract (Medicare, Medi-Cal Program). The three-way 2019 Cal MediConnect Contract between the Health Plan, DHCS, and CMS is on the CMS website. See sections 5.1.9 - 5.1.9.2 and 5.1.10.1. These requirements include but are not limited to timeliness of payment/denial of non-contracted provider claims, member denials, re-openings, adjustments, misdirected/forwarded claims, provider disputes, etc.

9.4.1 New Network Provider Training Oversight and Monitoring

To ensure Delegated Entity's newly contracted Cal MediConnect providers receive a new provider orientation, Blue Shield Promise will perform an audit of the organization to validate that all new providers were trained on Cal MediConnect Managed Care services, policies, procedures, and any modifications to existing services. New audit/documents templates are sent out annually or the Delegated Entity can contact Delegation Oversight Compliance Team.

9.4.2 Compliance Program Oversight and Monitoring

Delegation Oversight will perform a review of Delegated Entity's Compliance Program including assessment of the compliance material (program, P&Ps, etc.), training of staff, performance of internal audits, etc. This oversight is performed either via shared audit through ICE or individually on an annual basis.

9.4.3 IT System Integrity Oversight and Monitoring

Delegation Oversight will perform an IT system security and integrity audit to assure system access controls, policy and procedures regarding system changes, security of data, etc. are maintained. The oversight is also performed either via shared audit through ICE or individually on a bi-annual basis with quarterly monitoring.

Section 11: Health Education

Deleted *language specifying that providers are notified of updates to Preventive Health Guidelines via newsletters, provider visits, or fax and request copies of the guidelines through the Health Education Department. These guidelines are available on the Blue Shield Promise website.*

Added *a new section detailing the lifestyle program Wellvolution. Wellvolution is available to members at www.wellvolution.com/medicare.*

Section 14: Regulatory, Compliance and Anti-Fraud

14.7: Disclosure of Information to CMS

This section has been ***deleted and replaced*** *with the following language:*

Providers must provide Blue Shield Promise Health Plan, CMS, or the Department of Health Care Services (DHCS) with all information that is necessary for CMS and DHCS to administer and evaluate the Cal MediConnect program. Simultaneously, practitioners and providers must cooperate with Blue Shield Promise Health Plan in providing CMS/DHCS with the information CMS/DHCS needs to establish and facilitate a process to enable current and potential beneficiaries to get the information they need to make informed decisions with respect to available choices for the Medicare coverage.

14.8: Maintenance and Audit of Record

*This section has been **deleted and replaced** with the following language:*

The purpose of this requirement is to allow CMS and DHCS to evaluate the quality, appropriateness and timeliness of services, the facilities used to deliver the services and other functions and transactions related to CMS requirements. It applies to all parties in relation to service performed, reconciliation of benefit liabilities and determination of amounts payable. All parties are required to have their records available for a 10-year period after Blue Shield Promise Health Plan terminates the Cal MediConnect Three-Party Agreement with CMS and DHCS or the completion of an audit by the government, whichever is later (or longer in certain circumstances, if required by CMS). You must have books and records (including, but not limited to, financial, accounting, administrative and patient medical records and prescription drug files) available to support any activity with Blue Shield Promise Health Plan.

***Added** the following new section to comply with 42 C.F.R. Part 2 regulations:*

14.11: Confidentiality of Substance Use Disorder Patient Records

In 1975, Congress enacted 42 U.S.C. 290dd-2 and its supporting regulations at 42 C.F.R. Part 2. The law is formally referred to as the Confidentiality of Substance Use Disorder Patient Records Act, and informally referred to as "Part 2." The purpose of Part 2 is to protect the privacy of substance use disorder (SUD) patient records by prohibiting unauthorized use and disclosure of SUD patient records except with patient consent and in limited circumstances.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that regulates and enforces Part 2.

If, as a provider, you are a Part 2 Program, you must comply with all of the applicable legal requirements of the Part 2 laws and regulations.

To assist you in meeting your legal obligations, you may inform Blue Shield Promise that you have the patient's consent to disclose their SUD patient records to Blue Shield Promise when submitting an electronic claim (837 P or I) for Part 2 services by placing an "1" in the CLM09 field.

When submitting an electronic claim (837 P or I) for Part 2 services, under the NTE02 segment, you may include in the free-form narrative one of the following mandatory Part 2 disclaimer language options. The shorter version is preferable.

- 42 CFR part 2 prohibits unauthorized disclosure of these records; or
- This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

14.11: Confidentiality of Substance Use Disorder Patient Records *(cont'd.)*

To help you determine if you are a Part 2 Program, please refer to: https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf.

To learn more about the Part 2 laws and regulations, please refer to: https://www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-patient-records

To learn more about how Part 2 limits the disclosure of SUD patient records, please refer to: https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf

It is recommended that you consult legal counsel if you are uncertain whether or how these provisions apply to you.

Appendices

Appendix 1: Standardized Audit Tool

Deleted *the appendix. Go to iceforhealth.org and click on Library to view the audit tool.*

Appendix 2: Grievance Forms

Deleted *the appendix. See Section 3.3.2: Member Grievances above to learn how to submit a grievance online.*

Appendix 3: Utilization Management Timeliness Standards

Renamed *to Appendix 1: Utilization Management Timeliness Standards.*

Appendix 4: Prescription Drug Prior Authorization Form

Renamed *to Appendix 2: Prescription Drug Prior Authorization Form.*

Appendix 5: Practitioner/Provider Request to Terminate Patient/Provider Relationship Form

Renamed *to Appendix 3: Practitioner/Provider Request to Terminate Patient/Provider Relationship Form.* ***Updated*** *submission instructions on form. Email to promisehealthplanqualityreview@blueshieldca.com or fax to (323) 323-765-2702.*

Appendix 6: Access to Care Standards

Renamed *to Appendix 4: Access to Care Standards.* ***Deleted*** *initial prenatal, well-child and IHA standards from Attachment A that did not apply.* ***Added*** *the following access to care standards:*

Attachment B: Specialist Access to Care Standards

Urgent Vision Services	Vision services offered within 72 hours of request when it is consistent with the patient's individual needs and as required by professionally recognized standards of vision practice.
Non-Urgent Vision Services	Vision services are offered within 36 business days of the request for an appointment.
Preventative Care Vision Services	Vision services are offered within 40 business days of the request for an appointment.

Attachment C: Behavioral Health Access to Care Standards

Follow-Up Routine Care	**Within 30 Calendar Days** Follow-up routine care appointments are visits at later, specified dates to evaluate the patient progress and other changes that have taken place since a previous visit.

Appendix 7: Physician Direct Referral Form

Renamed *to Appendix 5: Physician Direct Referral Form.*

Appendix 8: Reimbursement for Outpatient Services

Deleted *this appendix. It was added to the manual in error.*

Appendix 9: List of Incidental Procedures

Deleted *this appendix. It was added to the manual in error.*

Appendix 10: List of Office-Based Ambulatory Surgery Procedures

Deleted *this appendix. It was added to the manual in error.*