blue california
Promise Health Plan

October 16, 2020

Subject: **Notification of January 2021 Updates to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual***

Dear Provider:

We have revised our *Blue Shield Promise Health Plan Medi-Cal Provider Manual.* 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 Medi-Cal Provider Manual* be mailed to you, once it is published, by emailing providermanuals@blueshieldca.com.

The *Blue Shield Promise Health Plan Medi-Cal Provider Manual* is referenced in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Medi-Cal providers contracted with Blue Shield Promise. If a conflict arises between the *Blue Shield Promise Health Plan Medi-Cal 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

TBSP11236 (10/20)

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

Section 5: Enrollment

5.12: Transportation

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

Non-emergency transportation (NEMT) 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).

The Physician Certification Statement (PCS) form must be completed and submitted before NEMT services can be prescribed and provided to the member.

The Non-Emergency Medical Transportation Authorization Request Form shall include, at a minimum, the outlined requirements in the most recent DHCS All Plan Letter 17-010: Non-Emergency Medical and Non-Medical Transportation Services for the Physician Certification Statement Form. The form is available to download from Blue Shield Promise's website, under Authorization Request Forms, in the Provider Forms section.

Blue Shield Promise shall not modify an NEMT authorization once the treating physician prescribes the form of transportation requested.

Section 6: Grievances, Appeals and Disputes

6.1 Member Grievances

***Added** contract information for Blue Shield Promise Member Services and the ways members can file grievances, in boldface type below:*

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: 711] for Los Angeles County and **(855) 699-5557 for San Diego County** or online, in writing by mail, fax or in person.

Grievances can be filed by telephone, in person, in writing by mail or fax, or online at **https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/medi-cal-members/medi-cal-members** under *Get to Know Your Medi-Cal program,* then *Submit a grievance form online.*

6.2 Member Appeals Requests

***Added** timeframe for expedited appeal resolution, in boldface type below:*

Expedited – **Resolved in 72 hours.** When the Member's life, health or ability to attain, maintain or regain maximum function is at risk.

6.4.2: Reconsiderations

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

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.

6.4.4: First Level Appeal

***Renamed** to Section 6.4.4 First Level Dispute. This section has been **deleted and replaced** with the following:*

A provider may dispute a denial decision made by Blue Shield Promise Health Plan or one of its PPG's.

1. The Provider shall be notified of receipt of written dispute 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. All records shall be evaluated by the appropriate Plan personnel who will render a decision. The Blue Shield Promise Health Plan Provider Dispute Department shall send a written determination letter outlining its conclusions with background information within 45 working days of receipt of the dispute. Language in the letter will include any available next steps the provider can take with the dispute.

6.4.5: Second Level Appeal

***Renamed** to Section 6.4.5 Second Level Dispute – LA County. This section has been **deleted and replaced** with the following:*

After completing a first level dispute, for L.A. County Medi-Cal only, the provider may submit a second level dispute. A second level dispute (De Novo) must be filed within 60 working days of receipt of the Blue Shield Promise Health Plan determination letter. 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 dispute, can be file 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 Dispute upon request.

If a Provider submits a written dispute directly to L.A. Care, the written dispute must contain:

1. A letter requesting a review of the first level dispute.
2. A copy of the letter sent to Blue Shield Promise Health Plan requesting a first-level dispute.
3. A copy of the original documents submitted to Blue Shield Promise Health Plan.
4. A copy of the first level dispute - denial determination letter.
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 dispute.

L.A. Care shall acknowledge and provide determination of the Second Level Dispute requested by the provider.

***Added** the following new section:*

6.4.6: Second Level Dispute - All Other Counties

After completing a first level dispute, the provider may submit a Provider Complaint to the Department of Managed Health Care (DMHC). The Provider Complaint can also be used when Blue Shield Promise Health Plan has failed to act within the deadlines set forth above.

Additionally, Providers may contact the DMHC Provider Complaint toll free number at (877) 525-1295.

Section 7: Utilization Management

7.7.3: Direct OB/GYN Access

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

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 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.

7.8.9: Mental Health (Medi-Cal Managed Care)

***Added** additional screenings that the Primary Care Physician is responsible for:*

- Trauma screenings: As a clinical best practice, Primary Care Physicians should screen children and adults for Adverse Childhood Experiences (ACEs), which research shows are strongly associated with increased health and social risks. Early detection of ACEs and timely intervention can help prevent or reduce these risks and support healing. Screen children for ACEs using a clinically appropriate trauma screening tool at least once per year, and adults at least once per lifetime, in accordance with DHCS' trauma screening guidelines. For more detailed information, visit, acesaware.org.
- Screening for prenatal and postpartum mental health conditions and referrals for mental health services as appropriate. Refer to Section 7.7.3: Direct OB/GYN Access for additional information.

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

***Added** a new section detailing the process and format for authorization logs required on a weekly basis:*

Weekly PPG Authorization Logs

Authorization/denial data files ("Authorization Logs") must be sent via secure email at IPAAuths@blueshieldca.com or SFTP file to Blue Shield Promise Health Plan.

Weekly PPG Authorization Logs *(cont'd.)*

Authorization logs must be sent on a weekly basis, at minimum, in order to ensure timely data processing. Approval and denial data may be delivered together on one weekly file or on separate weekly files. The logs MUST be delivered in a file format that is suitable for data processing such as an Excel spreadsheet or delimited fixed width file. Any data file which does not comply to the format, content requirements and/or delivery frequency will be rejected by Blue Shield and returned to the PPG for correction and resubmission.

Incomplete or inaccurate information may negatively impact claim processing. Please help expedite the processing of authorization/denial files by providing the following required information:

- Subscriber ID #
- Patient Last Name
- Patient First Name
- Patient Date of Birth (mm/dd/yyyy)
- Request Type (Inpatient, Service or Medication)
- Place of Service (Using CMS Industry Standard Place of Service Code Set and Name/Description: POS 11/Office, POS 21/Inpatient Hospital, POS 31/Skilled Nursing Facility)
- First date of service or First date authorized or denied (mm/dd/yyyy)
- Last date of service or Last date authorized or denied (mm/dd/yyyy)
- Admission Bed Type or Level of Care (Using industry standard descriptions: Acute Rehabilitation, Acute Behavioral Health, ICU, LTAC, Med Surg, NICU, NICU Level 1, Observation, SNF Level 1, Sub-Acute, ….)
- Diagnosis Code(s) (ICD-10-CM Codes) – Primary code and up to 3 additional codes, if applicable
- Procedure Code(s) (CPT-4/HCPC Codes and for inpatient facility claims only ICD-10-PCS Codes) – Primary code and up to 9 additional codes, if applicable
- Number of procedures, Quantity of units, frequency or number of visits (Home Health visits, Medication quantity or frequency, Lab visits, etc.)
- Servicing Provider Name
- Servicing Provider NPI #
- Facility Name (if applicable)
- Facility NPI # (if applicable)
- Requesting Provider Name
- Requesting Provider NPI #
- PPG Authorization or Decision Reference #
- Decision Date (mm/dd/yyyy)
- Decision (Approved, denied, partially denied or void); For partial denials, must specify what service, bed type/level of care (if applicable) and/or timeframes are denied vs. approved. Otherwise, a separate record for each must be provided on authorization log.

Only shared-risk and Blue Shield full-risk services are required on the data file. This will help reduce the volume of submissions and improve overall processing time.

7.10 Managed Long-Term Services and Supports (MLTSS)

*The following sections have been **deleted and replaced**:*

Managed Long-Term Services and Supports (MLTSS) refers to the delivery of long-term services and supports coordinated and overseen by Blue Shield Promise Health Plan. Programs range from services that support the members living in the community or in a skilled nursing facility. Community-Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP) support members living in the community. Long-Term Care (LTC) is provided in skilled nursing facilities. The following provides a more detailed description of these programs.

7.10.1 Community-Based Adult Services (CBAS)

CBAS is a community-based day health program that provides services to individuals 18 years of age or older that have a chronic medical, cognitive, or mental health condition and/or disabilities that place them at-risk of needing institutional care. The purpose is to delay or prevent institutionalization and maintain individuals in their homes and communities for as long as possible. 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 the following:

- 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

7.10.1.1 Accessing CBAS Services

Members must be assessed for program eligibility using the state mandated CBAS Eligibility Determination Tool ("CEDT"). To request a CEDT assessment, the member should be referred to a CBAS center of their choice. Alternately, the PCP or member may also contact Blue Shield Promise Health Plan Social Services department to obtain a list of CBAS centers near the member's home (877) 221-0208, from 8 a.m. to 5 p.m., Monday through Friday or providers can complete and submit the Blue Shield Promise Health Plan Social Services Referral Form which can be accessed on the Provider Portal. CBAS centers will request the member's medical history and physical in addition to an order for CBAS services from the member's PCP in order to enroll the member for CBAS services.

7.10.2 Multipurpose Senior Services Program (MSSP)

The Multipurpose Senior Services Program (MSSP) provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older, disabled, and that live within an MSSP site service area; services are an alternative to nursing facility placement allowing individuals to remain safely in their home. Services provided include:

- Case Management
- Personal Care Services
- Respite Care (in-home and out-of-home)
- Environmental Accessibility Adaptations
- Housing Assistance/ Minor Home Repair, etc.
- Transportation
- Chore Services
- Personal Emergency Response System (PERS)/ Communication Device

7.10.2 Multipurpose Senior Services Program (MSSP) *(cont'd.)*

- Adult Day Care / Support Center / Health Care
- Protective Supervision
- Meal Services - Congregate / Home Delivered
- Social Reassurance / Therapeutic Counseling
- Money Management
- Communication Services: Translation / Interpretation

Blue Shield Promise Health Plan Social Services Department will work with members who do not meet MSSP eligibility requirements to identify alternative services.

7.10.2.1 Accessing MSSP Services

There are six (6) MSSP Providers in LA County and one (1) MSSP provider in SD County who are responsible for determining program eligibility. If a Member is eligible, but placed on a wait list due to the limited number of slots available, the Blue Shield Promise Health Plan Social Services Department will work with the member, MSSP Provider, and other community-based providers to ensure the member receives assistance via other services and programs. A physician who believes a member might benefit from MSSP services can refer the member directly to the MSSP site serving the member's area or can refer to Blue Shield Promise Health Plan Social Services Department at (877)221-0208 or by completing and submitting the Blue Shield Promise Health Plan Social Services Referral Form which can be accessed on the Provider Portal.

7.10.3 Long-Term Care (LTC)

LTC is the provision of medical, social and personal care services in either an institution or private home. Most LTC services are provided in skilled nursing facilities ("SNFs"). The primary purpose of LTC is to assist the member in activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparing special diets and supervision of medication that can usually be self-administered.

To qualify for LTC, members must meet all criteria below:

- Be a Medi-Cal beneficiary
- Require 24-hour long or short-term medical care
- Eligible to receive services in a Skilled Nursing Facility

7.10.3.1 Accessing LTC

Referrals for LTC can come from a PCP, Discharge Planner, Family Caregiver or Interdisciplinary Care Team (ICT). A PCP who believes a member needs LTC should write an order to admit under Custodial Level of Care and must include a completed LTC Authorization Request Form and submit it to Blue Shield Promise Health Plan MLTSS/Long-Term Care Department for review (855) 622-2755, fax (844) 200-0121. This form can be accessed on the Provider Portal at Long-Term Care Authorization Request.

Once the LTC referral and physician order for Custodial Care have been received, Blue Shield Promise Health Plan will notify the referral source of the LTC referral outcome within five (5) business days for routine situations and 72 hours for urgent situations. Blue Shield Promise Health Plan MLTSS Department assists members with LTC by monitoring member progress, assisting with transitions outside of LTC, and coordinating LTC services with other health plan benefits.

Blue Shield Promise Health Plan LTC case managers will support the assigned physician with facilitation and coordination of care needs. Blue Shield Promise Health Plan LTC case managers also conduct regular telephonic clinical review of members in Long-Term Care.

7.11 Long-Term Services and Supports (LTSS)

*The following sections have been **deleted and replaced**:*

Additional Long-Term Services and Supports that help members live in the community include In-Home Supportive Services (IHSS). IHSS is a carved-out service, thus managed through entities outside of Blue Shield Promise Health Plan.

LTSS programs include:

7.11.1 In-Home Supportive Services (IHSS)

IHSS is a program managed by the state that pays for homecare services allowing seniors and individuals with disabilities (including children) to remain safely in their own homes and avoid institutionalization. Members who qualify hire their own IHSS caregiver to assist with personal care services, including the following:

- Personal Care (Bathing, grooming, dressing, feeding, incontinence care, toileting, fall prevention)
- Domestic services (cooking, light cleaning, laundry, grocery shopping)
- Paramedical services (medication management, medical appointment reminders)
- Protective supervision

To qualify for IHSS, a member must be a legal resident of California, living in his/her own home, receiving (or eligible to receive) Supplemental Security Income/State Supplemental Payment ("SSI/SSP") or Medi-Cal benefits, and 65 years of age or older, legally blind, or disabled by Social Security standards. The member must also submit a Health Care Certification Form (SOC 873) signed by a licensed health care professional indicating that they need assistance to stay living at home. This form is provided to members when they begin the application process.

7.11.1.1 Accessing IHSS

IHSS Program eligibility and service authorizations are determined by the Los Angeles/San Diego County Department of Public Social Services (DPSS). Once approved for services, a member is responsible for hiring, training and supervising the IHSS caregiver. Blue Shield Promise Health Plan Social Services Department can assist members with the following:

- Coordinating and navigating the IHSS assessment and re-assessment process
- Connecting the member to resources that can assist with locating a homecare worker

Physicians may refer members to the appropriate IHSS hotline based on the member's county of residence. For the Los Angeles County IHSS Application Hotline, contact (888) 944-4477. For San Diego County, contact (800) 510-2020. Call the Blue Shield Promise Health Plan Social Services Department at (877) 221-0208 or complete and submit the Blue Shield Promise Health Plan Social Services Referral Form online via the Provider Portal. Physicians will also need to complete the required IHSS forms and provide members with other documentation to support their need for IHSS.

Section 9: Quality Improvement

9.1: 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.*

9.4: 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.

9.6 Initial Health Assessment

***Added** additional health assessment screenings for members aged 21 and over.*

Procedure

***Deleted** item #5 regarding the outreach system 4Patient Care. **Added** the following new language:*

6. If a member cancels an appointment or does not show up for the appointment, outreach (at least 3 attempts) to the member must be conducted within 48 hours to reschedule the appointment. All outreach must be documented in the member's medical record.

***Added** the following new section:*

Blue Shield Promise and PCP Shared Member Outreach Process

In efforts to improve the effectiveness and efficiency of member outreach to schedule an IHA appointment, Blue Shield Promise has partnered with our primary care providers. This collaborative approach allows for the "sharing" of member phone calls and letters, as well as outreach and scheduling data. Our efforts thus far have shown an increase in member and provider satisfaction, and an overall increase in timely IHA appointments. Blue Shield Promise would like to extend this collaborative opportunity to additional PCP practices. We invite you to learn more by contacting the IHA Outreach and Monitoring Team at IHAMonitoring@blueshieldca.com. We look forward to partnering with you on these efforts.

9.9.1: 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.

9.10.1: 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.**

9.14.2 Credentials Process for Participating Provider Groups

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;
    - Medi-Cal Suspended and Ineligible Provider List at Initial and Recredentialing
    - Member complaints; and
    - Identified adverse events.
- PPG is responsible for Identifying Qualified HIV/AIDS Specialist in accordance with CA H&SC §1374.16; DMHC TAG (QM-004), DHCS MMCD All-Plan Letter 01001)
    - The PPG must develop and implements policy and procedures describing the process that the organization identifies and reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist, according to California State regulations on an annual basis. The Department of Managed Health Care (DMHC) issued a definition of an HIV/AIDS specialist and criteria which can be accessed at dmhc.ca.gov
    - Annually conducts screening of HIV/Aids Specialists to ensure qualifications and criteria of the DMHC are met.
    - Notify department responsible for authorizing standing referrals of its physician's that qualify as HIV/AIDS specialists according to DMHC regulations.

Section 10: Pharmacy & Medications

Effective January 1, 2021, the Department of Health Care Services (DHCS) will transition Medi-Cal pharmacy services from the Medi-Cal managed care delivery system to a Medi-Cal fee-for-service delivery system. This new Medi-Cal fee-for-service delivery system will be called, Medi-Cal RX. Magellan will be the pharmacy benefit manager that will administer Medi-Cal Rx benefits.

The pharmacy benefit management and administration for our Medi-Cal membership will be carved out and will be transition to Magellan, DHCS' contracted pharmacy benefit management vendor. Blue Shield of California Promise Health Plan will continue to provide medical benefits and support services such as provider network, customer care support, and utilization management for prescription medication that are covered under the medical benefit and appeals and grievances for services covered under the medical benefit.

Blue Shield of California Promise Health Plan will be in compliance with all DHCS All Plan Letter (APL) related to this carve out. For more information about the Medi-Cal Rx program visit https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx.

Section 12: Provider Services

12.7 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.

12.7.1 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.

12.7.4: 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 to Provider Information & Enrollment that the PCP wishes to change from 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.

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

12.7.6: Network Validation

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

6. Blue Shield Promise's Provider Directory Protocol:

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 14: Claims

14.3: Coordination of Benefits (COB)

Added *the following language:*

Prior to delivering services to members, providers must review the Medi-Cal eligibility record for the presence of Other Health Coverage (OHC). If the member has OHC, providers must compare the OHC code (found in Appendix A on the DHCS website at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-010AttA.pdf) to the requested service. If the requested service is covered by the OHC, providers are to instruct the member to seek the service from the OHC carrier. As stated in Title 42 U.S. Code section 1396a(a)(25)(D), regardless of presence of OHC, providers should not refuse a covered Medi-Cal service to a Medi-Cal member.

a) If a member has OHC, provider should consider OHC plan as the Member's primary health plan.
b) If the member has OHC, the provider shall submit a claim for Covered Services provided to the member to the OHC prior to submitting the claim to Blue Shield Promise.
c) Blue Shield Promise shall remain the secondary health plan and payer of last resort for Medi-Cal eligible members.
d) If a Member has coverage for medical, other care, or treatment benefits under more than one (1) OHC plan, the provider should bill the primary health plan for the medical, other care, or treatment benefits. Blue Shield Promise Medi-Cal members will be considered the secondary health plan and payer of last resort.

Prior to January 1, 2021, providers may access the necessary member OHC information utilizing the Automated Eligibility Verification System at (800) 427-1295, or the Medi-Cal Online Eligibility Portal. Information pertaining to OHC carriers can be found in the Health and Human Services Open Data Portal.

14.6 Claims Oversight and Monitoring – Participating Provider Groups

Renamed *to Section 14.6 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.

14.6 Claims Oversight and Monitoring – Participating Provider Groups *(cont'd.)*

Blue Shield Promise 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 Medi-Cal Provider Dispute 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, an annual claims and PDR audit. 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. For those Delegated Entities who are subject to DMHC audits, if deficiencies are determined during the review, a corrective action plan (CAP) is required to be sent to Blue Shield Promise. Additionally, Blue Shield Promise may perform an unannounced audit dependent upon other indicators.

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 California Title 28 (1300.71 and 1300.71.38), California Health & Safety Section 1371 and various state bills – AB1324, etc. These requirements include, but are not limited to, timeliness of claims processing (denials, adjustments, payment), misdirected/forwarded claims timeliness, accuracy of denials/contesting, payment of family planning claims, etc.

14.6.1 New Network Provider Training Oversight and Monitoring

To ensure Delegated Entity's newly contracted providers receive a new provider orientation within ten (10) business days of becoming a participating Medi-Cal provider with your organization, Blue Shield Promise will perform an audit of the organization according to published audit timeframes to validate that all new providers were trained on Medi-Cal Managed Care services, policies, procedures, and any modifications to existing services. Evidence of training is required to be submitted to the Blue Shield Promise Delegation Oversight Compliance Team for audit/review. Your organization is required to submit annual training materials for new contracted providers, updates to training material to existing providers, and information shared for out-of-network providers. New audit/documents templates are sent out annually or you can contact the Delegation Oversight Compliance Team.

14.6.2 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.

14.6.3 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 16: Regulatory, Compliance and Anti-Fraud

Added *the following language 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.

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 4: Social Services Department Referral Form

Updated *form.*

Appendix 7: Blue Shield Promise Health Plan Access to Care Standards

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 16: 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 18: Reimbursement for Outpatient Services

Renamed *to Appendix 18: Reimbursement for Ambulatory Surgery Centers.* ***Updated*** *to only include reimbursement for outpatient surgery services performed at an ASC. The other outpatient services payment methodologies are not applicable to the Medi-Cal line of business and were added in error.*

Appendix 19: List of Incidental Procedures

Added *the following codes:*

15772	Grfg autol fat lipo ea addl
15774	Each addl 25cc
20700	Prep and insert drug del dev
20701	Removal (deep)
20702	Prep and insert drug del dev
20703	Removal (intramedullary)
20704	Prep and insert drug del dev
20705	Removal (intra-articular)
C9756	Fluorescence lymph map w/icg

Appendix 19: List of Incidental Procedures *(cont'd.)*

Deleted *the following codes:*

0341T	Quant pupillometry w/rpt
0399T	Myocardial strain imaging

Appendix 20: List of Office-Based Ambulatory Surgery Procedures

Added/updated *the following procedure codes:*

20560	Needle insert w/o inj 1 or 2 mscl
20561	Needle insert w/o inj 3 or more
64454	Inj Aa&/Strd Gen Nrv Brnch w/img
64624	Dest neurolytic agt gen nrv w/img
0551T	Tprnl balo cntnc dev adjmt
0563T	Evac Meibomian gld heat bilat
0566T	Autol cell impt adps tiss njx implt knee uni
0588T	Rev or rem isdns post tibial nrv

Deleted *the following procedure codes:*

0380T	Comp animat ret image series
0482T	Absolute quant myocardial bld flow