Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

February 26, 2020

Subject: **Notification of May 2020 Updates to the *Blue Shield Promise Health Plan Medicare Provider Manual***

Dear Provider:

We have revised our *Blue Shield Promise Health Plan Medicare Provider Manual.* The changes listed on the following pages are effective May 1, 2020.

On that date, you can search and download the revised manual on the Blue Shield Promise Provider Portal at https://www.blueshieldca.com/promise/providers/index.asp, click on *Providers* on the top, then *Provider Manual* in the drop down list.

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

The *Blue Shield Promise Health Plan Medicare Provider Manual* is referenced in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Medicare providers contracted with Blue Shield Promise. If a conflict arises between the *Blue Shield Promise Health Plan Medicare 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 May 2020 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

TBSP10891 (2/20)

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Section 1: Provider Services

1.4: Provider Affiliations

Removed *this section as providers are no longer limited to five (5) affiliations.*

1.4: Provider Network Additions (Participating Provider Group "PPG")

Renumbered *section to 1.4 and* ***updated*** *this section to indicate the addition of a PPG provider requires submission of a provider profile to the to the Blue Shield Provider Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.*

1.5.5: Change in a Provider's PPG Affiliation

Renumbered *section to 1.5.5 and* ***removed*** *the requirement that the PCP send a separate notification of change in affiliation to Blue Shield Promise. This request needs to be sent to the PPG only.*

1.6.6: Change in a Provider's Panel Status

Removed *the requirement that the Provider notify the DMHC of panel status inaccuracies.*

Section 2: Credentialing

2.3: Minimum Credentials Criteria

Updated *American Podiatric Medical Association Board names, as follows:*

- Podiatrists (DPM) are required to be either board certified by a Board recognized by the American Podiatric Medical Association (e.g., American Board of Foot and Ankle Surgery (ABFAS) [formerly American Board of Podiatric Surgery (ABPS)] or the American Board of Podiatric Medicine (ABPM) [formerly American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)].

2.6: Credentials Process for Participating Provider Group (PPG)

Updated *the methodologies used to conduct file review for pre-delegation and annual audits, as follows:*

a. The NCQA 8/30 file review methodology. Prior to the audit, the Blue Shield Promise Health Plan 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 Health Plan 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.

b. The NCQA 5 percent or 50 file review methodology of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.

- After completion of the initial file review, the auditor will follow the same procedure for the recredentialed files review.

Section 7: Quality Improvement

7.1: Quality Improvement Program

Updated *language in boldface type below:*

- Monitoring, evaluating, and taking effective action to address any needed improvements in the quality of care delivered to **enrollees, including our Cal-Medi-connect members and** Seniors and People with Disabilities (SPD). **Monitoring shall be done in accordance with the policies and procedures set forth in the Provider Manual and all requirements of Applicable Governmental Agency/Agencies legal requirements.**

7.1.3: Quality Improvement Process

Added *the following language regarding compliance with the QI Program:*

Contracted providers, including IPA/Medical Groups, are required to abide by and comply with the provisions of, and participate in, Plan's Quality Improvement Program (including the applicable Model of Care) as described in this Provider Manual.

Contracted providers, including IPA/Medical Groups, shall comply with all Blue Shield Promise administrative policies and procedures as described in this Provider Manual, as well as with all applicable state and federal laws and regulations relating to the delivery of Covered Medical Services. Providers/Medical Groups may appeal adverse determinations in accordance with the procedures established by Blue Shield Promise Health Plan.

Failure to comply with the requirements of the Quality Improvement Program or to abide by Blue Shield Promise's policies and procedures may be deemed by Blue Shield Promise as a material breach of this Agreement, and may, at Plan's option, be grounds for termination of contract.

Quality of Care Reviews

Added *the following language:*

Provider monitoring related to quality of care occurs on an ongoing basis as new potential quality issues are received and on an aggregate basis along with service complaints at least every six months.

Section 8: Encounter Data

8.1: Encounter Data – Medicare and Cal Medi-Connect

Rewrote *entire section to align with current policies and procedures, as follows:*

Policy and Procedures

Encounter Data Submission

Blue Shield Promise Organization and Procedures

Capitated IPAs and medical groups are required to submit all encounter data to Blue Shield Promise, including encounters for primary care, specialty care, and ancillary services.

For both Medicare Advantage and Cal Medi Connect encounter data, submissions may be made directly to Blue Shield Promise or via a vendor. Regardless of the route of submission, providers may request the professional and facility encounter data specifications and procedures from Blue Shield Promise using the contact information below. Encounter data must be submitted in HIPAA compliant ANSI 837P and 837I formats.

8.1: Encounter Data – Medicare and Cal Medi-Connect *(cont'd.)*

Medicare Encounter Data

EDI Operations: (800) 480-1221 - EDI questions only.

For encounter processing questions call the Customer Service number on back of the member's card.

Vendors

A list of approved vendors can be found on Provider Connection at blueshieldca.com/provider. Click on *Claims*, *Manage Electronic Transactions,* then *Enroll in Electronic Data Interchange*. You may also contact the EDI Help Desk at (800) 480-1221.

Performance - Regular and Complete Submission of Encounter Data

COMPLIANCE GUIDELINES

Monthly Submission

It is a Blue Shield Promise requirement that encounter data be submitted at least once each month and each submission must be in the correct HIPAA Compliant electronic format with usable data. Files with significant data quality problems may be rejected and may require correction of problems. The Medical Group must meet all data quality measurements established by Blue Shield Promise and is responsible for correcting and re-submitting all rejections to Blue Shield Promise 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. 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.

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

Providers who are contracted with Blue Shield Promise 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.

Complete Submission

Volume of the Data

The Centers for Medicare & Medicaid Services' (CMS) payment methodology is a risk-adjusted payment rate based on the reporting of encounter data. Therefore, it is important to comply with encounter submission requirements and to report all services appropriately to meet established Encounter data Quantity targets.

For Medicare Advantage and Cal Medi Connect encounter data submissions to the CMS, there is also a compliance measurement reflecting the data collection period. Benchmarks using Evaluation and Management (E&M) CPT codes are used. The benchmarks are:

Medicare Advantage and Cal Medi Connect Membership: 8.0 E&M Visits PMPY

Blue Shield Promise will measure encounter submissions based on a rolling year of utilization data and certain types of denied services are included in calculating each IPA/medical group's annual E&M visit rates.

8.1: Encounter Data – Medicare and Cal Medi-Connect *(cont'd.)*

Medicare Denials

All denied Medicare Advantage encounters should be submitted to Blue Shield, except for duplicate encounters and eligibility denials.

A provider network contract may include an incentive program or capitation withhold provision that would apply for performance, relative to the above benchmarks. The current performance target is at least 90% of the benchmark.

In addition, Blue Shield Promise will analyze the completeness of encounter data submissions for specialty and ancillary services.

Quality of the Data

The Blue Shield Promise Health Plan collects information regarding the utilization of primary care, hospital inpatient and outpatient, specialty and ancillary services by its Members. Data acceptance rate shall not be less than 90% of all data submitted. Medical Group is responsible to correct the rejections and re-submit the corrections to Blue Shield Promise within 10 days of notice received.

Blue Shield Promise requires that, on a periodic basis, an officer of the IPA/medical group attest to the completeness and truthfulness of encounter data submission.

Timeliness of the Data

Encounter records shall be submitted within thirty (30) calendar days from Date of Service ("DOS") in which care was rendered.

Maximum Out of Pocket

Beginning April 1,2014, the Centers for Medicare & Medicaid Services (CMS) requires EOBs for Medicare Advantage members with Medicare Part C. IPAs are required to submit encounter submissions with Maximum Out-of-Pocket "MOOP" for Medicare Advantage members.

Blue Shield Promise will measure encounter submissions based on a rolling year of utilization data. The Centers for Medicare & Medicaid Services (CMS) requires EOBs for Medicare Advantage members with Medicare Part C. IPAs are required to submit encounter submissions with Maximum Out-of-Pocket "MOOP" for Medicare Advantage members.

Section 9: Claims

9.1: Claims Submission

Updated *claims submission language to indicate that claims are required to be submitted electronically unless the provider contract states otherwise, as follows:*

Providers are required to submit claims electronically that do not have a medical record attached unless the provider contract specifically states otherwise. Claims are submitted in the ASC X12 837 5010 format. To enroll in electronic claim submission, providers can use any clearinghouse with established Blue Shield of California connectivity. Blue Shield Promise claims must be submitted via Office Ally or Change Healthcare. Primary clearing houses are listed on Provider Connection blueshieldca.com/provider in the *Claims* section under *How to submit claims* or by contacting the EDI Department at (800) 480-1221.

9.1: Claims Submission *(cont'd.)*

Updated *the paper claim mailing address to:*

Blue Shield Promise Health Plan
Exela – BSCPHP
P.O. Box 272660
Chico, CA 95926

Claim Filing Limits

Updated *the claims filing timeframes to the following:*

Providers must submit clean claims to Blue Shield Promise Health Plan within the timeframe specified in your contract.

9.2: Claims Processing Overview

Added *the following new sections to align with language in the revised provider agreement.*

K. Hospital-Acquired Conditions / Never Events

Plan will not pay or otherwise reimburse participating hospitals for inpatient services related to those HACs and Never Events listed on Provider Connection at https://www.blueshieldca.com/bsca/bsc/wcm/myconnect/provider/provider_content_en/claims/policies_guidelines/payment_policies.

A copy of the medical record and an itemization of charges must be submitted with acute care hospital claims for inpatient admissions during which there was a Hospital-Acquired Condition (HAC) or Never Event.

L. Incidental Procedures

Incidental procedures are outpatient services provided to members in conjunction with other outpatient covered services. Incidental procedure services and supplies are considered included in a global procedure charge(s). A list of incidental procedures is provided in Appendix 9.

M. Facility Compliance Review (FCR)

In order to comply with our employer group and provider contract agreements and to ensure that appropriate billing practices are followed, the Plan has developed a comprehensive Facility Compliance Review (FCR) program that involves a comprehensive line-by-line bill audit. The program reviews inpatient and outpatient claims to validate their conformance with provisions of the facility's agreement.

The Plan audits claims for billing accuracy, allowable charges, medical necessity, Hospital Acquired Conditions and Never Events to ensure consistency with currently accepted standards in the industry. These standards include but are not limited to those defined by Optum reference manuals and followed by other commercial payors, as well as the UB 04 Billing Manual guidelines and the National Uniform Billing Committee guidelines. The program encompasses Plan claims for all lines of business and all facilities.

9.2: Claims Processing Overview *(cont'd.)*

Facility Compliance Review (FCR) *(cont'd.)*

Categories of charges that are subject to review and payment denial include but are not limited to those charges that are mutually agreed to in Plan's contracts (e.g., Disallowed Charges); those charges that are determined to be not medically necessary; those for which there is no substantiating documentation; and those considered to be unbundling of another global charge, such as room and board charges or other facility room charges. Precedence for denial of such charges has been established by Optum resource manuals, and other commercial payors, as well as the Uniform Bill (UB04) Billing Manual guidelines and definitions.

To complete an audit as expeditiously as possible, Blue Shield may ask a hospital to submit medical records; Emergency Room Notes, Trauma Flowsheet, Physician Progress Notes, Physician Orders, History and Physical, Consultations, Discharge Summary, Operative Report and Implant Log. Blue Shield may request a copy of the UB 04 (or successor) and a detailed itemization if the claim has been electronically submitted. Timely submission of requests will expedite claims processing.

For questions regarding this program, please contact Provider Information & Enrollment at (800) 258-3091.

Appeals to the Facility Compliance Review results must be submitted in writing and include specific detailed supporting documentation to the following address:

Blue Shield Initial Appeal Resolution Office
Attention: Hospital Exception and Transplant Team
P.O. Box 629010
El Dorado Hills, CA 95762-9010

9.4 Claims Oversight and Monitoring – Participating Provider Groups

Updated *section to expand on the claims oversight and monitoring process, as follows:*

Blue Shield Promise Health Plan 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 monthly and quarterly claims processing timeliness via the PPG's submission of the monthly/quarterly timeliness report. Additionally, Blue Shield Promise monitors the PPG's provider dispute resolution process via submission of the PPG's quarterly CMS_Qtr_ProvDisp Rpt. Both report templates are located on the ICE website under Approved ICE documents. Blue Shield Promise performs at the minimum annual claims and PDR audits. Follow-up/focused audits will be scheduled by the assigned auditor if the PPG fails the annual and subsequent audit(s). Additionally, Blue Shield Promise may perform an unannounced audit dependent upon other indicators. Blue Shield Promise audits include review of PPG's claims and PDR processing according to contractual and regulatory requirements, including but not limited to 42 CFR 422.520 and redeterminations 42 CFR 405.940 - 405.958. 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.

Delegation Oversight will also perform review of PPG's Compliance Program including assessment of the PPG's Compliance Program material (program, P&Ps, etc.), training of staff, performance of internal audits, etc. Additionally, system integrity audit will be conducted to assure that data is not able to be manipulated, modified or deleted. These audits will be conducted annually or as needed based upon other indicators.

For the Cal MediConnect Program (Medicare, Medi-Cal Program), Blue Shield Promise will be auditing according to regulatory requirements 42 CFR 447.45. Additionally, PPGs can reference the three-way contract between the Health Plan, DHCS and CMS on the CMS website. See sections 5.1.9 - 5.1.9.2 and 5.1.10.1 of the 2019 Cal MediConnect Contract.

Added *the following new section to align with language in the revised provider agreement.*

9.5: Third Party Liability (TPL)

If a member is injured or becomes ill due to the act or omission of another person (a "third party"), the Plan and the provider will provide the necessary treatment according to plan benefits. If the member receives a related monetary award or settlement from the third party, third party insurer or from uninsured or underinsured motorist coverage, Plan and the hospital or facility have the right to recover the cost of benefits paid for treatment of the injury or illness. The total amount of recovery will be calculated according to California Civil Code Section 3040.

The member is required to:

1. Notify the Plan and the provider in writing of any claims or legal action brought against the third party as a result of their role in the injury or illness within 30 days of submitting the claim or filing the legal action against the third party;
2. Agree to fully cooperate and complete any forms or documents needed to pursue recovery from the third party;
3. Agree, in writing, to reimburse the Plan for benefits paid from any recovery received from the third party;
4. Provide a lien calculated according to California Civil Code Section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Respond to information requests regarding the claim against the third party and notify the Plan and the provider in writing within ten (10) days of any recovery obtained.

Section 10: Accounting

10.3: Shared Savings Program and Reports

Added *the following new sections to align with language in the revised provider agreement.*

For certain services not covered under capitation, the Plan and the IPA/medical group share financial risk, as defined by the IPA/medical group's contract with the Plan.

In most arrangements, the IPA/medical group is allocated a certain percentage of the CMS revenue and a certain percentage of the Employer Group revenue as shared savings budget. The Plan administers shared savings claims and the expenses for the IPA/medical group's assigned members are debited from the shared savings budget. Any annual surplus or deficit for the shared savings budget is shared between the IPA/medical group and the Plan according to the terms in the IPA/medical group's the Plan contract.

Any Plan Medicare Advantage services rendered during a particular agreement year, but not reported to the Medicare Advantage Plan within the predetermined amount of days as stated in the contract after the end of the same agreement year, shall be included in the shared-risk computation for the subsequent agreement year.

If an IPA/medical group has questions regarding a Shared Savings claim, the IPA/medical group can submit the detailed claim records in question to the Managed Care Finance Department of the Plan. The submitted file should have the same layout format as the claim files that were previously sent to them. A column needs to be added to the end of the file for all comments explaining why the claims are being questioned. In addition, the submitted file should only include the claims that are in question. Please note that this process does not replace or change the DMHC Provider Dispute Process.

Quarterly Financial Performance File

The Quarterly Financial Performance File is based on a 90-day fund pool performance (for physician organizations participating in a shared savings program). This report itemizes information on member months, capitation paid, institutional fund allocations, depletions and balances by year-to-date. This report is supported by claim detail for both current and prior year for all applicable fund pools.

Shared-Risk Claims

The Plan will process all claims for which the IPA/medical group and the Plan share financial responsibility. Whenever the Plan receives shared-risk claims that contain capitated components, The Plan will process its portion of the claim and will forward the capitated service portion to the appropriate IPA/medical group for processing.

> *Example: The Plan receives an in-area emergency room (ER) services claim. The Plan will process the claim and identify the ER Professional Services as a capitated service on the EOB. The capitated services will be forwarded to the appropriate IPA/medical group for processing.*

The Plan will also process all claims for services for which the Plan has sole responsibility.

Institutional Services Budget

In an arrangement where hospitals are not capitated for institutional services, the Plan maintains an Institutional Services Budget (for physician organizations participating in a shared savings program). The Institutional Services Budget is a shared savings fund in which the Plan and IPA/medical groups share any surplus based on a negotiated settlement formula.

In general, the Plan provides a quarterly and annual accounting of the shared savings fund and the services paid by the Plan from these funds. Each IPA/medical group receives from the Plan a quarterly and annual Shared Savings report that contains the Shared Savings statement and the claims detail files.

Appendices

Appendix 6: Blue Shield Promise Health Plan Access to Care Standards

*The Access to Care Standards have been **updated** to align with the Access to Care Standards and Monitoring Process Policy and Procedures effective 12/6/19. The updated Access to Care Standards are located on the Blue Shield Promise provider portal at* https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms.

***Added** the following appendices to the manual. These appendices are referenced in the revised provider agreements and point to the provider manual for more information on these topics.*

Appendix 8: Reimbursement for Outpatient Services

This appendix lists a summary of the reimbursement method and a calculation example(s) for outpatient services.

Appendix 9: List of Incidental Procedures

This appendix lists billable CPT codes for incidental procedures.

Appendix 10: List of Office-Based Ambulatory Surgery Procedures

This appendix lists billable CPT codes for ambulatory surgery procedures.