blue california
Promise Health Plan

January 31, 2022

Subject: **Notification of January 2022 Updates to the *Blue Shield Promise Health Plan Cal MediConnect Provider Manual***

Dear Provider:

We have revised our *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, 2022.

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 PDF version of the revised *Blue Shield Promise Health Plan Cal MediConnect Provider Manual* be emailed to you or mailed to you in CD format, 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 2022 version of this manual, please contact Blue Shield Promise Provider Services at (800) 468-9935.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

TBSP12449 (1/22)

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association L52000-W-PHP (1/20)

UPDATES TO THE JANUARY 2022
BLUE SHIELD PROMISE HEALTH PLAN CAL MEDICONNECT MANUAL

Section 5: Utilization Management

5.2.1: Authorization Timeframes

Expedited Initial Organization Determination (EIOD)

Added *language in boldface type below:*

Blue Shield Promise provides written notification to Members and practitioners a reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based. Blue Shield Promise notifies Members of the reason for the denial in clear and understandable language. **The reason(s) for denial must be translated into the Member's preferred language.**

Section 6: Pharmaceutical Management

6.3.1: Prior Authorizations and Exceptions

Removed *language below:*

Prior authorization requests can be sent electronically through the electronic health record, if available, or faxed requests may be sent to (866) 712-2731.

Section 9: Claims

9.2: Claims Processing Overview

Deleted and replaced *the language in subsection F (Overpayment Recovery) with the following:*

Blue Shield Promise will notify provider of service, in writing, within 365 calendar days from the date of last payment to initiate an overpayment request. The provider of service must respond within 30 working days to contest and/or refund the overpayment. Blue Shield Promise will offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission if (1) the provider fails to reimburse within the 30-working day timeframe and (2) the provider has entered into a written contract specifically authorizing Blue Shield Promise to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions.

If a provider contests Blue Shield Promise's overpayment request within 30 working days, the Plan will treat the challenge as a Provider Dispute.

Section 12: Culturally and Linguistically Appropriate Services (CLAS)

12.1: Provider Responsibility in the Provision of CLAS

Added *the following in boldface type below:*

Translation of Member-Informing and Health Education Materials

Blue Shield Promise makes specific materials available in any language that is the primary language of more than ten percent of its geographic service area. Such materials may include but are not limited to:

- Summary of Benefits
- Annual Notice of Change
- Evidence of Coverage
- Appeals and Grievance letters
- **Notice of Action (NOA), including clinical rationale**
- **Notice of Appeal Resolution (NAR), including clinical rationale**

Section 14: Regulatory, Compliance, and Anti-Fraud

Added *subsection 14.11(False Claims Act) and renumbered remaining section:*

14.11: False Claims Act

The False Claims Act (FCA) (31 U.S.C. Sections 3729-3733) imposes liability on any person or organization that submits a claim to the federal government that is known (or should be known) to be false and allows citizens with evidence of fraud against government contracts and programs to sue on behalf of the government in order to recover stolen funds.

The FCA provides a way for the government to recover money when someone submits or causes to be submitted false or fraudulent claims for payment to the government, including the Medicare and Medi-Cal programs.

Examples of health care claims that may be false include claims where the service is not actually rendered to the patient, is provided but is already provided under another claim, is up-coded, or is not supported by the patient's medical record.

Claims also may be false if they result from referrals made in violation of the Federal Anti-kickback statute or the Stark law.

When the government pursues violations of the False Claims Act, it does not target innocent billing mistakes. False claims are claims that the provider knew or should have known were false or fraudulent. "Should have known" means deliberate ignorance or reckless disregard of the truth. This means providers cannot avoid liability by ignoring inaccuracies in their claims. Health care providers need to understand the program rules and take proactive measures, such as conducting internal audits within their organizations, to ensure compliance.

If a provider makes an innocent billing mistake, that provider still has a duty to repay the money to the government.

For False Claims Act violations, a provider can be penalized up to three times the program's loss, also known as treble damages. The False Claims Act provides a strong financial incentive to whistleblowers to report fraud. Whistleblowers can receive up to 30 percent of any False Claims Act recovery.

Providers must ensure that the claims they submit to Medicare and Medi-Cal are true and accurate. One of the most important steps a provider can take is to have a robust internal audit program that monitors and reviews claims. If a provider identifies billing mistakes in the course of those audits, the provider must repay overpayments to Medicare and Medi-Cal within 60 days to avoid False Claims Act liability.

It is the provider's responsibility to consistently submit accurate claims.

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